# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03334 **CERTIFICATE OF DEATH** 03327

1 (M)

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be ex[illegible] in 24 hours after de[illegible] Page 4 [illegible]be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely [illegible]ed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8513-CARROLL AVENUE

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 20 SILVER SPRING
d. STREET ADDRESS: 8513-CARROLL AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First MIRIAM — Middle - — Last AARONSON

**4. DATE OF DEATH**: Month MARCH — Day 10. — Year 1962

**5. SEX**: FEMALE
**6. COLOR OR RACE**: WHITE
**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: Aug-11-1921
**9. AGE** (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): —
**10b. KIND OF BUSINESS OR INDUSTRY**: —
**11. BIRTHPLACE** (County & State, or foreign country): BALTO., MD.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: WOLF AARONSON
**14. MOTHER'S MAIDEN NAME**: SARAH GRUSDA

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO
(If yes give war or dates of service): -
**16. SOCIAL SECURITY NO.**: NONE
**17. INFORMANT**: HENRY AARONSON (BRO) Address 906 NAVAHOE DR. SSPG MD

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
DUE TO (b) Hypoplastic ANEMIA — over 15 yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
293 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.): No
**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from APRIL 28, 1947 to MARCH 10, 1962, that (I) (we) last saw the deceased alive on MARCH 10 1962, and that death occured at 10:05 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Israel Kessler, M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3/10/62
**22c. PHYSICIAN'S NAME** (Type): ISRAEL KESSLER, M.D
**22d. ADDRESS**: 801-16th St. N.W.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**23b. DATE THEREOF**: 3/11/62
**23c. NAME OF CEMETERY OR CREMATORY**: B'NAI ISRAEL CEM
**23d. LOCATION** (City, town or county) (State): OXON HILL, MD

**24. FUNERAL DIRECTOR'S SIGNATURE**: Goldberg Funeral Home
**ADDRESS**: 4217-9th Ave
**25a. REC'D BY REGISTRAR DATE**: MAR 12 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kruse

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03335 **CERTIFICATE OF DEATH** 03328

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 15 minutes
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Irving Middle: Leo Last: Aleshire

**4. DATE OF DEATH**: Month: mar. Day: 18 Year: 1962

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: March 17, 1922

**9. AGE** (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Road Department

**10b. KIND OF BUSINESS OR INDUSTRY**: Truck Driver

**11. BIRTHPLACE** (County & State, or foreign country): Luray, Va.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: John Aleshire

**14. MOTHER'S MAIDEN NAME**: Hester ~~Mayock~~ Smith

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Yes
(If yes give wars or dates of service): WW # 2

**16. SOCIAL SECURITY NO.**: 578-20-0706

**17. INFORMANT**: Hospital Records
Address

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA, ACUTE
DUE TO (b) MYOCARDIAL INFARCT, OLD, HEALED
DUE TO (c) CORONARY ARTERIOSCLEROSIS

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 hour / several months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS - (HYPERNEPHROMA L. KIDNEY) INCIDENTAL FINDING

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3/17, 1962 to 3/18, 1962, that (I) (we) last saw the deceased alive on 3/18, 1962, and that death occured at 12:45 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: G. F. Meadors M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/18/62

**22c. PHYSICIAN'S NAME** (Type): G.F. MEADORS, MD

**22d. ADDRESS**: DAMASCUS, MD.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/21/62

**23c. NAME OF CEMETERY OR CREMATORY**: Montgomery Meth.

**23d. LOCATION** (City, town or county) (State): Clagettsville, Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Olin L. Mobsworth

ADDRESS: Damascus, Md.

**25a. REC'D BY REGISTRAR** DATE: MAR 22 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03336 **CERTIFICATE OF DEATH** 03329

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 44 BETHESDA
d. STREET ADDRESS: 5822 LONE OAK DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First NELLIE — Middle R. — Last ALLEN

**4. DATE OF DEATH**: Month MARCH — Day 10 — Year 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/25/81
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): CAMBRIDGE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: NICHOLS G. HENRY
14. MOTHER'S MAIDEN NAME: CORNELIA RADCLIFFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
16. SOCIAL SECURITY NO. (If yes give wer or dates of service): Yes
17. INFORMANT — Address: DAUGHTER, MRS. BETTY MOSSBURG

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 to 72 hrs
DUE TO (b) Myocardial infarct — 12 days
DUE TO (c) Coronary atherosclerosis — years

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED — While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1957 to March 9, 1962, that (I) (we) last saw the deceased alive on March 9 1962, and that death occured at 6:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Allen J. O'Neill M.D.
22b. DATE SIGNED
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): Allen J. O'Neill, MD
22d. ADDRESS: 8601 Old Georgetown Rd Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/13/62
23c. NAME OF CEMETERY OR CREMATORY: Parkawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: MAR 14 '62
25b. REGISTRAR'S SIGNATURE: Carlton L. Hume

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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03337

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

03330

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10,205 Douglas Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Silver Spring
d. STREET ADDRESS: 10,205 Douglas Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie; Middle: R.; Last: Alsop
4. DATE OF DEATH: Month: March; Day: 9; Year: 19 62
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 2, 1885
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Barrett
14. MOTHER'S MAIDEN NAME: Emile Gale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: ~~58~~ 579-30-2198
17. INFORMANT: Carl E. Alsop 10205 Douglas Ave, S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
DUE TO
(b) Arteriosclerotic Heart Disease
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Tuberculosis 002.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 23, 1961, to March 9, 1962, that (I) (we) last saw the deceased alive on March 9 1962, and that death occurred at 11:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Richards M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-9-62
22c. PHYSICIAN'S NAME (Type): Edward J. Richards
22d. ADDRESS: 10,110 Georgia Ave, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-13-62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Prince George's Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Pumphrey
ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE MAR 13 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03338 **CERTIFICATE OF DEATH** 03331

Item 7 Film G309 2/19/62 iwk

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 4½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
d. STREET ADDRESS: 4860 Chevy Chase Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY Middle Dorsey Last AMISS
4. DATE OF DEATH: Month March Day 11 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Married
8. DATE OF BIRTH: 2/21/1885
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Retirk~~ Salesman-ret
10b. KIND OF BUSINESS OR INDUSTRY: Meat products
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edmund L. Amiss
14. MOTHER'S MAIDEN NAME: Angeline Greene
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 577-07-4520
17. INFORMANT: Helen F. Amiss-wife-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

527.1

DUE TO (b) Auricular Fibrillation — Many Years

DUE TO (c) Frequent Pneumonias — " "

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Emphysema — " "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from ....., 1932 to Mar 10, 1962 that (I) (we) last saw the deceased alive on Mar 10 1962 and that death occured at 5:35 AM from the causes and on the date stated above.

22a. SIGNATURE: Bradley D Hodgkins M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Bradley D. Hodgkins
22d. ADDRESS: 4413 Bradley Lane Chevy Chase Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/14/62
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery
23d. LOCATION (City, town or county) (State): Gaithersburg, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 14 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. See page 4 for instructions. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03339 **CERTIFICATE OF DEATH** 03332

Item 23b Film 0310 4/2/62 mh

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**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 38 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: South Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Folly Beach 77X·3
d. STREET ADDRESS: 105 W. Erie Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Louis Martin Anderson Jr.

4. DATE OF DEATH: Month / Day / Year: March 20, 1962

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 12, 1961
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months: 6 Days: 9 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (County & State, or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Martin Anderson Sr.
14. MOTHER'S MAIDEN NAME: Carol Ann Cornelius

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT: FATHER: Louis M. Anderson Sr., Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration pneumonitis
DUE TO (b) Brain Damage
DUE TO (c) Hypoglycemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

27 OX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~XX~~ (this hospital) attended the deceased from February 10, 1962 to March 20, 1962, that (I) (we) last saw the deceased alive on March 20, 1962, and that death occured at 6:50 PM from the causes and on the date stated above.

22a. SIGNATURE: Frederic A. Schulaner M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 21, 1962
22c. PHYSICIAN'S NAME (Type): Frederic A. Schulaner LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 23, 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Per Le Roy Pumphrey
Robert A. Pumphrey Funeral Home, 7557 Wisc.Ave., Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

VR A15 (4)
15M 7/61

1177

Daughter, Susanna L.
Susan Dunning
Mary Coleman

1

FOR STATE HEALTH DEPT.

M

X

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2

2

1

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any de[illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03340 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03333

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 16 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 610 Pershing Drive

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 Silver Spring
d. STREET ADDRESS: 610 Pershing Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: George — Middle: (nmi) — Last: Argerake

**4. DATE OF DEATH**: Month: March — Day: 6 — Year: 19 62

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 3/14/1897

**9. AGE** (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Gro. Clerk

**10b. KIND OF BUSINESS OR INDUSTRY**: N&B Delicatessen

**11. BIRTHPLACE** (State or foreign country): ~~Greech~~ Greece

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Edward Argerake

**14. MOTHER'S MAIDEN NAME**: Maria Chagaroulis

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.**: yes

**17. INFORMANT**: Patricia J. Argerake 610 Pershing Dr. S.S., Md. — Address

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Peracerdial Tamponade — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Rup. of heart

DUE TO (c): Myocardial infarction — 7 to 10 das.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.): Auto Accident

**20c. TIME OF INJURY** Hour: 5:00 ~~A.M.~~ p.m. — Month, Day, Year: Sept. 1960 19

**20d. INJURY OCCURRED** While at work ☒ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): ~~NX~~. Highway

**20f.** (City or town): Wash. — (County) — (State): D.C.

**21. I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

**ACTUAL SIGNATURE** Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

**DATE SIGNED**: March 7, 1962

**EXAMINER'S NAME** (Type): Frank J. Broschart — Address (Street, city, town, or county)

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 3-8-62

**22c. NAME OF CEMETERY OR CREMATORY**: Glenwood Cemetery

**22d. LOCATION** (City, town, or country): Washington, D.C. — (State)

**23. FUNERAL DIRECTOR**: Raymond A. Zisca — ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland

**24a. REC'D BY REGISTRAR** DATE: MAR 8 '62

**24b. REGISTRAR'S SIGNATURE**: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03341 Items 1 & 2 Film G308 3/12/62 iwk 03334

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): ~~Rockville~~ Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Manor Club Estates

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Rockville~~ Rockville,
d. STREET ADDRESS: Carrolton & Norbeck Manor Club Estates
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charlotte Middle Louise Last Ballard
4. DATE OF DEATH: Month 3 Day 3 Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 19, 1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George H. Langhenry
14. MOTHER'S MAIDEN NAME: Amelia S. Lambert
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give year or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Burton M. Langhenry Address: Manor Club Estates, Rockville Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO (b) Carcinoma of Cecum — 6 months
DUE TO (c)
1530
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 1-29, 1962, to 3-3-, 1962, that (I) ~~(we)~~ last saw the deceased alive on 2-28-, 1962 and that death occured at N/A M, from the causes and on the date stated above.

22a. SIGNATURE: C. Roger Kurtz M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-3-62
22c. PHYSICIAN'S NAME (Type): C. Roger Kurtz, M.D.
22d. ADDRESS: 3701 Connecticut Ave NW. Wash 8, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-6-62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Bladensburg Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home ADDRESS: 4812 Ca. Ave., N.W., Wash., D.C.
25a. REC'D BY REGISTRAR: DATE MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Chelsea L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03342

# CERTIFICATE OF DEATH

Reg. Dist. No. 03335

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 KENSINGTON
d. STREET ADDRESS: 3908 BALTIMORE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle L. Last BARKER

4. DATE OF DEATH: Month March Day 11 Year 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-28-76
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: Millwright
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ZACKWELL MORGAN BARKER
14. MOTHER'S MAIDEN NAME: MARY ELLEN RIGGS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 235-12-7287
17. INFORMANT: DAUGHTER MRS MILDRED HARMAN Address: S/A

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
(b): Uremia — 4 days
DUE TO
(c): Pyelitis and Prostatitis — 4 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC, 1955, to 3/11, 1962, that I last saw the deceased alive on 3/11, 1962, and that death occurred at 2 30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Y. Joggers Jr. M.D.
ADDRESS (Street, city or town, state): 5707 Wisconsin Ave
DATE SIGNED: 3/11/62
PHYSICIAN'S NAME (Type): FRANK Y. JOGGERS JR. Chevy Chase 15, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-13-62
22c. NAME OF CEMETERY OR CREMATORY: Colesville Cemetery
22d. LOCATION (City, town, or county) (State): Colesville Montgomery Co, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Ave Silver Spring, Maryland
24a. REC'D BY REGISTRAR: DATE MAR 14 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03343 **CERTIFICATE OF DEATH** 03336

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12hrs. 25mins.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 1536 - Independence Ave. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Henry — Last: Barnes
4. DATE OF DEATH: Month: March — Day: 31 — Year: 1962

5. SEX: male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/18/17
9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10b. KIND OF BUSINESS OR INDUSTRY: Drug Co.
11. BIRTHPLACE (County & State, or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frances Barnes.
14. MOTHER'S MAIDEN NAME: Frances Mack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Chloe Barnes — Address: Same As Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) STATUS ASTHMATICUS — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b) ADRENAL INSUFFICIENCY — 12 hr.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

241X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/31/62 19.., to 3/31/62 19.., that (I) (~~we~~) last saw the deceased alive on 3/31/62 19.., and that death occured at 6.45 p.m., from the causes and on the date stated above.

22a. SIGNATURE: John E. Everett M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/1/62
22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT
22d. ADDRESS: 9400 Conn Ave Kensington Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/4/1962
23c. NAME OF CEMETERY OR CREMATORY: Lincoln
23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: William Rishe — ADDRESS: W. Ernest Jarvis Co., Inc. 1432 You Street, N.W.
25a. REC'D BY REGISTRAR DATE: APR 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03344

## CERTIFICATE OF DEATH

03337

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 14511 Colesville Rd. Marilea Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 Silver Spring
d. STREET ADDRESS: 901 Snider Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First / Middle / Last: Alpha L. Beck

4. DATE OF DEATH: Month: March; Day: 26; Year: 1962

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/29/87
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elsworth M. Eastwood
14. MOTHER'S MAIDEN NAME: Dena F. Huffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 579-48-8280
17. INFORMANT: Edward R. Beck
Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Chronic myocardial disease — 3 mo.
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour: a. m. / p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 2, 1962 to March 26, 1962 that (I) (we) last saw the deceased alive on March 22, 1962 and that death occurred at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John S. Rogers, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 26, 1962
22c. PHYSICIAN'S NAME (Type): John S. Rogers
22d. ADDRESS: 1919 Seminary Rd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3/29/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03345 **CERTIFICATE OF DEATH** 03338

M

50

I

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 60 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Flintstone — 01X.2
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

**3. NAME OF DECEASED** (Type or print): First: Walter; Middle: Wayne; Last: Bender

**4. DATE OF DEATH**: Month: March; Day: 26; Year: 19 62

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 20 October 1938
9. AGE (In years last birthday): 23 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter L. Bender
14. MOTHER'S MAIDEN NAME: Eva Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. **INFORMANT**: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

201X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

2

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 25, 1962, to March 26, 1962, that (I) (we) last saw the deceased alive on March 26, 1962, and that death occured at 7:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Michael Field M.D.
22b. DATE SIGNED: March 26, 1962
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. PHYSICIAN'S NAME (Type): Michael Field, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

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23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/29/62
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland
25a. REC'D BY REGISTRAR DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Clarence S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03346 **CERTIFICATE OF DEATH** 03339

Item 8 Film 0308 3/9/62 mh

M

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Silver Spring
d. STREET ADDRESS: 309 Belton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75

**3. NAME OF DECEASED** (Type or print): First: Mary; Middle: ; Last: Berkowitz

**4. DATE OF DEATH**: Month: 3; Day: 5; Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: 12-17-1882
**9. AGE** (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): H.W. CORSETIERRE RETIRED
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (County & State, or foreign country): Poland
**12. CITIZEN OF WHAT COUNTRY?**: NON CITIZEN

**13. FATHER'S NAME**: JEROME LEVINSON
**14. MOTHER'S MAIDEN NAME**: DEBORAH

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**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO (If yes give wer or dates of service)
**16. SOCIAL SECURITY NO.**: 102-03-4248
**17. INFORMANT**: GEORGE BLOOM Address: 309 BELTON Rd. SS Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12 Hours
DUE TO (b) Congestive Heart Failure — Un Known
DUE TO (c) Hyper Tensive Heart Disease — Un Known

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 43X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1) Gastro Intestinal Bleeding 2) Bronchopneumonia 3)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 4, 1962 to March 5, 1962 that (I) (~~not~~) last saw the deceased alive on March 5 1962, and that death occured at 3:15 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Stuart L. Nelson M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-5-62
22c. PHYSICIAN'S NAME (Type): STUART L. NELSON, M.D.
22d. ADDRESS: 7600 CARROLL AVE. TAK. PK. MD

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23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MARCH 6, 1962
23c. NAME OF CEMETERY ~~OR CREMATORY~~: MT. HEBRON CEMETERY
23d. LOCATION (City, town or county): FLUSHING L.I. (State): NY

24 FUNERAL DIRECTOR'S SIGNATURE: Bernard Bluzgunsky & Sons ADDRESS: 3501-14th St NW
25a. REC'D BY REGISTRAR DATE MAR 7 '62
25b. REGISTRAR'S SIGNATURE: Clinton S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03347 **CERTIFICATE OF DEATH** 03340

Item 2 Film 0310 1/5/62 mk

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Resmor Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND (Va.)
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (West Point)
d. STREET ADDRESS: 5724 Grosvenor Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First MARY Middle ELIZABETH Last BESWICK

**4. DATE OF DEATH** Month 3 Day 26 Year 1962

**5. SEX:** FEMALE
**6. COLOR OR RACE:** W
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐
**8. DATE OF BIRTH:** 11-28-1881
**9. AGE** (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY:** —
**11. BIRTHPLACE** (County & State, or foreign country): ENGLAND
**12. CITIZEN OF WHAT COUNTRY?** U.S.

**13. FATHER'S NAME:** William Richard Webb
**14. MOTHER'S MAIDEN NAME:** Mary Elizabeth Dutton

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes give war or dates of service): —
**16. SOCIAL SECURITY NO.:** Unknown
**17. INFORMANT** Address: HERBERT G. BESWICK

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO (b) HEART FAILURE (? INFARCTION) — 1-DAY
DUE TO (c) ARTERIO SCLEROTIC HEART DISEASE — 20+ YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): RHEUMATOID ARTHRITIS, EPILEPSY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Month, Day, Year Hour a.m. p.m. 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 12/22/57, 19..., to 3/26, 1962, that (I) (we) last saw the deceased alive on 3/24 1962, and that death occured at 8:15 A.M. from the causes and on the date stated above.

**22a. SIGNATURE** Charles J. Savarese M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED** 3/26/62
**22c. PHYSICIAN'S NAME** (Type) CHARLES J. SAVARESE, MD
**22d. ADDRESS** 4890 BATTERY LA. BETHESDA, MD

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF:** 3/29/62
**23c. NAME OF CEMETERY OR CREMATORY:** Hopewell Cemetery
**23d. LOCATION** (City, town or county) (State): Hopewell, Virginia

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
**25a. REC'D BY REGISTRAR** DATE MAR 30 '62
**25b. REGISTRAR'S SIGNATURE** Arthur S. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03348

## CERTIFICATE OF DEATH

Reg. Dist. No. 03341

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 407 University Blvd, West

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Silver Spring.
d. STREET ADDRESS: 407 University Blvd, West
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Kathleen; Middle: (NMI); Last: Bettinger

**4. DATE OF DEATH**: Month: March; Day: 30; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Sept 11, 1923

**9. AGE** (In years last birthday): 38 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own home

**11. BIRTHPLACE** (State or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Joseph Bloomer

**14. MOTHER'S MAIDEN NAME**: Catherine V. Finnan

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service): None

**16. SOCIAL SECURITY NO.**: 101 14 5048

**INFORMANT**: Catherine Finnan — Address: 407 University Blvd, W Silver Spring, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO (b) Liver failure — 1 mo
DUE TO (c) Metastatic Carcinoma of Breast — 3 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1 2 0 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rt. mastectomy, April 1960.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a. m. p. m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from January, 1953, to March 30, 1962, that I last saw the deceased alive on March 29, 1962, and that death accurred at 12:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Raymond Bradshaw, Jr. M.D. — ADDRESS (Street, city or town, state): 345 University Blvd, W. — DATE SIGNED: 3/30/62

PHYSICIAN'S NAME (Type): Raymond Bradshaw, Jr. — Silver Spring, Md

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 4-2-62

**22c. NAME OF CEMETERY OR CREMATORY**: Gate of Heaven Cemetery

**22d. LOCATION** (City, town, or county) (State): Silver Spring, Montgomery Co. Md.

**23. FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Zinn — ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc., Silver Spring, Maryland

**24a. REC'D BY REGISTRAR** DATE: APR 2 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03349 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03342

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 203 Croyden Ave

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09 Rockville
d. STREET ADDRESS: 203 Croyden Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Thompson Last: Blanks Jr.
4. DATE OF DEATH: Month: Mar Day: 29 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 7-6-08
9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): T.V. Repair
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lynchburg, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert T. Banks
14. MOTHER'S MAIDEN NAME: Frankie ~~Frances~~ Lazenby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 719-05-2664
17. INFORMANT: Robert T. Blanks III — Address: 5201 Fordyce Place -Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b) Shot gun wound Thru skull
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted shot gun wound Thru skull
20c. TIME OF INJURY Hour ~~a.m.~~ p.m. ? Month, Day, Year 3-29 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Rockville (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 3-29-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
22b. DATE THEREOF: 4/2/62
22c. NAME OF CEMETERY OR CREMATORY: [redacted] Springhill
22d. LOCATION (City, town, or country) (State): Lynchburg, Virginia
23. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Montg. Ave. Rockville, Maryland
24a. REC'D BY REGISTRAR DATE APR 3 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03350 **CERTIFICATE OF DEATH** 03343

Item 23b, Film G309 3/15/62 iwk

1 M

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 122 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): San Diego 43 x 3
d. STREET ADDRESS: 4231 Santa Cruz Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Esther; Middle: Lillian; Last: Bogenholm
4. DATE OF DEATH: Month: March; Day: 8; Year: 1962
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 20, 1907
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): San Diego, California
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John P. Feeny
14. MOTHER'S MAIDEN NAME: Mary A. Hachatt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT: HUSBAND: Wilbor T. Bogenholm, Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 24 HOURS.
DUE TO (b) JAKOB-CREUTZFELDT SYNDROME — 1 YR.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
355 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (☒ (this hospital) attended the deceased from Nov. 6, 19.61 to March 8, 19.62, that (☒ (we) last saw the deceased alive on March 8, 1962, and that death occured at 4:08PM from the causes and on the date stated above.

22a. SIGNATURE: John W. Brackett Jr. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 9, 1962
22c. PHYSICIAN'S NAME (Type): JOHN W. BRACKETT JR., LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/11/62
23c. NAME OF CEMETERY OR CREMATORY: Holy Cross
23d. LOCATION (City, town or county) (State): San Diego, California

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave. Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03351 **CERTIFICATE OF DEATH** 03344

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN 1b: 2 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4306 Curtis Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CHEVY CHASE
d. STREET ADDRESS: 4306 CURTIS ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CHRISTINA Middle ANNA Last BOSE
4. DATE OF DEATH: Month 3 Day 12 Year 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: FEB 3, 1873
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WOODRIDGE N.J.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JULIUS SANS
14. MOTHER'S MAIDEN NAME: BARBARA ANN VOLKER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: AGNES M. HARRIS Address: McDANIEL, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 5 days
527
DUE TO (b) PULMONARY EMPYSEMA & FIBROSIS. — 15 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ARTERIAL OCCLUSION LEFT POPLITEAL
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 1959, to MARCH 12, 1962 that (I) (we) last saw the deceased alive on MARCH 11 1962, and that death occured at 30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert N. Coale M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 12, 1962
22c. PHYSICIAN'S NAME (Type): ROBERT N. COALE
22d. ADDRESS: 4429 BRADLEY LANE, CHEVY CHASE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 3/15/62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town or county) (State): Brooklyn, New York

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03352 03345

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Washington Grove
c. LENGTH OF STAY IN 1b: 14 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 416 5th Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington Grove 07
d. STREET ADDRESS: 416 5th Ave 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edwin Middle Hinton Last Bowling
4. DATE OF DEATH: Month Mar Day 13 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-3-1900
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: E. H. Bowling
14. MOTHER'S MAIDEN NAME: Mimi Jackson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Augusta Bowling (wife) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4204
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: Mar 13-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/15/62
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
22d. LOCATION (City, town, or county) (State): Arlington Co Va
23. FUNERAL DIRECTOR: Chevy Chase Funeral Home
ADDRESS: 5923 Wis Ave Chevy Chase Md
24a. REC'D BY REGISTRAR: DATE MAR 15 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

1

FOR STATE HEALTH DEPT.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03353 03346

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4405 East West Hgwy. apt 210

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Bethesda (apt 210)
d. STREET ADDRESS: 4405 East West Hgwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Douglas — Middle: Adair — Last: Boykin
4. DATE OF DEATH: Month: March — Day: 5 — Year: 1962
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-17-09
9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months: 2, Days: 18 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ala.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Clarence Boykin
14. MOTHER'S MAIDEN NAME: Mary Adair
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): ~~No~~ Yes — (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: Yes Unknown
17. INFORMANT: Dorothy Boykin (wife) — Address: Stem 2

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thoracic hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Shot gun wound in left chest (heart)
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

976 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted shot gun wound (12 gauge)
20c. TIME OF INJURY: Hour 7 a.m. p.m. — Month, Day, Year: 3-5 1962
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Bethesda — (County): Monty — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschard M.D.
EXAMINER'S NAME (Type): FRANK J. Broschard
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-5-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Bremation
22b. DATE THEREOF: 3/7/62
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or country) (State): Suitland, Maryland

23. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Maryland — ADDRESS
24a. REC'D BY REGISTRAR: DATE MAR 9 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Thoma

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03354 03347

1 M 74 I 0 1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 5401 Galena Pl., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Daniel Middle: A. Last: Boyle

**4. DATE OF DEATH**: Month: March Day: 19 Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 9/7/87

**9. AGE** (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Thomas Boyle

**14. MOTHER'S MAIDEN NAME**: Elizabeth Casey

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no (If yes give war or dates of service): —

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Elva Boyle, wife Address: same as above

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS
DUE TO (b) RUPTURED APPENIX with PERITONITIS — 7 DAYS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 550

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Dec, 195[illegible], to March, 19 62 that (I) (we) last saw the deceased alive on 3/19 1962, and that death occured at 1P M, from the causes and on the date stated above.

**22a. SIGNATURE**: Leo I Donovan M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/19/62

**22c. PHYSICIAN'S NAME** (Type): LEO I DONOVAN M.D.

**22d. ADDRESS**: 8215 WISC AVE BETH 14 MD

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: MAR. 22, 1962

**23c. NAME OF CEMETERY OR CREMATORY**: MT. OLIVET CEMETERY

**23d. LOCATION** (City, town or county) (State): WASHINGTON D.C.

**24 FUNERAL DIRECTOR'S SIGNATURE**: H. Don. DeVol

ADDRESS: 2224-Wis. Ave

**25a. REC'D BY REGISTRAR** DATE MAR 22 '62

**25b. REGISTRAR'S SIGNATURE**: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03355 **CERTIFICATE OF DEATH** 03348

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 49 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83X-3
d. STREET ADDRESS: 1309 South Taylor Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Harold — Middle: Chester — Last: Braun

**4. DATE OF DEATH**: Month: March — Day: 23 — Year: 19 62

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

**8. DATE OF BIRTH**: 24 June 1902

**9. AGE** (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Service Manager

**10b. KIND OF BUSINESS OR INDUSTRY**: Department Store

**11. BIRTHPLACE** (County & State, or foreign country): Pennsylvania

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: George Braun

**14. MOTHER'S MAIDEN NAME**: Josephine Slater

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 173-12-6576

**17. INFORMANT** Address: The Medical Record, The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforated Duodenal Ulcer with peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 - 7 days
181.6
DUE TO (b) Advanced Carcinoma of Bladder — 2 yrs. 9 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED: While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Feb. 2, 1962, to March 23, 19 62 that (I) (we) last saw the deceased alive on March 23, 19 62 and that death occured at 10:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Yosef H. Pilch M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: March 23, 1962

22c. PHYSICIAN'S NAME (Type): Yosef H. Pilch, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-25-62

23c. NAME OF CEMETERY OR CREMATORY: Evergreen

23d. LOCATION (City, town or county) (State): Luray Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: DM Eichenberger — ADDRESS: Vienna Virginia

25a. REC'D BY REGISTRAR — DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03356

## CERTIFICATE OF DEATH

03349

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Takoma Park
d. STREET ADDRESS: 8600 Glenview Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Arthur Middle: Tillman Last: Britt

**4. DATE OF DEATH** Month: 3 Day: 24 Year: 1962

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 1-10-20

**9. AGE** (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Main Tenance - Library of Cong

**10b. KIND OF BUSINESS OR INDUSTRY**: U.S. Government

**11. BIRTHPLACE** (County & State, or foreign country): Georgia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: William F. Britt

**14. MOTHER'S MAIDEN NAME**: Eva M. Sullivan

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown)

**16. SOCIAL SECURITY NO.** (If yes give wer or dates of service)

**17. INFORMANT** Address: Hospital Record.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Hepatic Coma | 1 week |
| DUE TO (b) | Advanced Cirrhosis of Liver | 6 years |
| DUE TO (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia Severe Hypoalbuminemia Hypopostatic Pneumonia

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) ~~(this hospital)~~ attended the deceased from Aug 13, 1956 to March 24, 1962 that (I) ~~(—)~~ last saw the deceased alive on March 23, 1962 and that death occured 3:59 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: Russell B. Arnold M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/24/62

**22c. PHYSICIAN'S NAME** (Type): Russell B. Arnold M.D.

**22d. ADDRESS**: 8801 Colesville Road, Silver Spring, Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: March 27-1962

**23c. NAME OF CEMETERY OR CREMATORY**: George Washington Cemetery

**23d. LOCATION** (City, town or county) (State): Adelphi. Md

**24. FUNERAL DIRECTOR'S SIGNATURE**: Arthur Walters.
ADDRESS: 254 Carroll St. N.W. Takoma Park DC

**25a. REC'D BY REGISTRAR** DATE: MAR 28 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03357 **CERTIFICATE OF DEATH** 03350

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1 6 M 75 I 2 1

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium + Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 24
d. STREET ADDRESS: 604 Bonifant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bernice — Middle: Clara — Last: Broome
4. DATE OF DEATH: Month: Mar — Day: 20 — Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 3-20-01
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HW
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: McClain
14. MOTHER'S MAIDEN NAME: Not Available
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3/18/62.
260X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Diabetes Mellitus — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/11/, 1952 to 3/20/, 1962 that (I) (we) last saw the deceased alive on 3/20/ 1962, and that death occured at 3:05 M, from the causes and on the date stated above.

22a. SIGNATURE: Howard T Morse M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/20/62
22c. PHYSICIAN'S NAME (Type): Howard T Morse
22d. ADDRESS: 7030 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 23, 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St, N.W. Wash, D.C.
25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSP[illegible]L OR ATTENDING PHYSICIAN:** The law requires that the death certificate be execu[illegible] [illegible]thin 24 hours a[illegible] death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03358

## CERTIFICATE OF DEATH

03351

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rockville, maryland.
d. STREET ADDRESS: 705 marshall Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Lyda; Middle: Mae; Last: Broome

**4. DATE OF DEATH**: Month: mar; Day: 22; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Jan 3, 1919

**9. AGE** (In years last birthday): 43 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home

**11. BIRTHPLACE** (County & State, or foreign country): Columbia S. Carolina

**12. CITIZEN OF WHAT COUNTRY?**: USA.

**13. FATHER'S NAME**: William P. Swygert

**14. MOTHER'S MAIDEN NAME**: LYDA Roberts.

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: 578-14-9440

**17. INFORMANT**: milton Broome — Address: 705 marshall Ave Rockville md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Toxemia, hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b) adrenal cortical failure
DUE TO (c) stress ulcer (gastric), intestinal fistulas — 6 yrs

274 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): previous advanced cancer uterus, fistulas

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year: Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1-5-52, 19.., to 3-22, 1962 that (I) (we) last saw the deceased alive on 3-21, 1962 and that death occured at 11:35 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: John O Robben M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/23/62

**22c. PHYSICIAN'S NAME** (Type): JOHN O. ROBBEN

**22d. ADDRESS**: 1015 Spring St Silver Spring Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: 3/26/62

**23c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill Cemetery

**23d. LOCATION** (City, town or county) (State): Suitland, Maryland

**24. FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Zeka
ADDRESS: WARNER E. PUMPHREY INC. 8434 GEORGIA AVE., SILVER SPRING, MD.

**25a. REC'D BY REGISTRAR** DATE MAR 27 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Travis

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director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5 (4)
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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03359 **CERTIFICATE OF DEATH** 03352

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Silver Spring
d. STREET ADDRESS: 4302 Ferrara Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donald Middle: Kenneth Last: Brown

4. DATE OF DEATH: Month: March Day: 24, Year: 19 62

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 18, 1922
9. AGE (In years last birthday): 40 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Naval Officer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Jesse Brown
14. MOTHER'S MAIDEN NAME: Edna Viola Wearth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 538 26 9705
17. INFORMANT: WIFE: Address: Mrs. Edna P. Brown, Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO (b) Coronary insufficiency
DUE TO (c) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 25 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from March 23, 19 62 to March 24, 19 62 that (X) (we) last saw the deceased alive on March 24, 19 62, and that death occured at 11:32 AM from the causes and on the date stated above.

22a. SIGNATURE: Joseph H. Eusterman M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 24, 1962
22c. PHYSICIAN'S NAME (Type): JOSEPH H. EUSTERMAN LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-30-62
23c. NAME OF CEMETERY OR CREMATORY: Ivy Lawn Cemetery
23d. LOCATION (City, town or county) (State): Oxnard, California

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Funeral Home, 1400 Chapin St. NW
ADDRESS: Wash., D.C.
25a. REC'D BY REGISTRAR DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

W W Chambers

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03360 03353

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park Md
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. + Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Silver Spring
d. STREET ADDRESS: 609 Univ. Blvd. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Philip — Middle: Peter — Last: Brown

4. DATE OF DEATH: Month: March — Day: 18 — Year: 19 62

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-29-83
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plate Printer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVERNMENT
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert J. Brown
14. MOTHER'S MAIDEN NAME: Isabel F Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Washington San. + Hosp. — Address: Takoma Park Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b) Cerebral Vascular Occlusion — 5 days
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cholecystectomy (Stone Post) 3-8-62
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar 17, 1962, to Mar 18, 1962 that (I) (~~we~~) last saw the deceased alive on Mar 18 1962, and that death occured at 5:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: John P. Haberlin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/18/62
22c. PHYSICIAN'S NAME (Type): John P. Haberlin
22d. ADDRESS: 1015 Spring St Silver Spring

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-21-62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George's Co. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zicka — ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03361

## CERTIFICATE OF DEATH

03354

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 44 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
d. STREET ADDRESS: 8714 Leonard Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel; Middle: (No middle name); Last: Burgess
4. DATE OF DEATH: Month: March; Day: 6; Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1 November 1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse & Office worker
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Sedgwick
14. MOTHER'S MAIDEN NAME: Sarah Hall Decker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record, — Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Necrotizing pneumonia left lower lobe and lingula, right lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(b) Viral hepatitis with early post hepatitic cirrhosis — 2 months
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

0 92X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Status post operative total pelvic exenteration for Epidermoid Carcinoma of the uterine cervix.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 21 1962 to March 6, 1962, that (I) (we) last saw the deceased alive on March 6 1962, and that death occured at 9:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: Yosef H. Pilch, M.D. — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 6, 1962
22c. PHYSICIAN'S NAME (Type): Yosef H. Pilch, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3-9-62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: H. Don. DeVol — ADDRESS: 2224 Wis Ave NW
25a. REC'D BY REGISTRAR: DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Charles S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

Item 10 Film 310 4-5

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03362

## CERTIFICATE OF DEATH

03355

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 231 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda, 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harrisburg,
d. STREET ADDRESS: 1720 North 3rd Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75 x 3

**3. NAME OF DECEASED** (Type or print): First: Jane — Middle: Charlotte — Last: Burley

**4. DATE OF DEATH**: Month: March — Day: 22, — Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 14 July 1921
9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Paul Timothy
14. MOTHER'S MAIDEN NAME: Catherine Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give year or dates of service):
16. SOCIAL SECURITY NO.: Not available
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterial Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 48 Hours
152.7
DUE TO (b) Malignant Carcinoid (primary tumor of the distal ileum)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
Pneumothorax, left

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 3, 1961, to March 22, 1962, that (I) (we) last saw the deceased alive on March 22 19 62, and that death occured at 11:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Michael Field M.D.
22b. DATE SIGNED: 3-23-62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Michael Field M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/26/62
23c. NAME OF CEMETERY OR CREMATORY: East Harrisburg Cem.
23d. LOCATION (City, town or county) (State): Harrisburg, Penna.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 27 '62
25b. REGISTRAR'S SIGNATURE

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

03363 03356

**1. PLACE OF DEATH**
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days 23 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 29
d. STREET ADDRESS: 1206 - Noyes Drive
e. IS RESIDENCE ON A FARM? YES [X] NO [X]

**3. NAME OF DECEASED** (Type or print): First: Jewel Middle: Le Maria Last: Burns

**4. DATE OF DEATH**: Month: 3 Day: 12 Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

**8. DATE OF BIRTH**: 7/10/99

**9. AGE** (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): BEAUTICIAN

**10b. KIND OF BUSINESS OR INDUSTRY**: Beauty Culture

**11. BIRTHPLACE** (County & State, or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Martin Le Maria

**14. MOTHER'S MAIDEN NAME**: Josephine De Pasquale

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no

(If yes give war or dates of service): no

**16. SOCIAL SECURITY NO.**: 577-36-0123H

**17. INFORMANT**: Edward A. Burns Address: 1206 Noyes Dr. Silver Sp. Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE | (a) Carcinoma of Breast c Metastasis | 6 years |
| DUE TO | (b) Acute Heart Failure | 6 mos. |
| DUE TO | (c) | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES [ ] NO [X]

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER):

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work [ ] Not While at work [ ]

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 6/1, 1955 to 3/12, 1962, that (I) (we) last saw the deceased alive on 3/12 1962, and that death occured at 4:00 P.M., from the causes and on the date stated above.

**22a. SIGNATURE**: John E. Everett M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

**22b. DATE SIGNED**: 3/12/62

**22c. PHYSICIAN'S NAME** (Type): JOHN E. EVERETT

**22d. ADDRESS**: 9400 CONN AVE Kensington Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-16-62

**23c. NAME OF CEMETERY OR CREMATORY**: Gate of Heaven Cemetery

**23d. LOCATION** (City, town or county) (State): Silver Spring Montgomery Co., Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Zaken ADDRESS: 8434 Georgia Ave

Warner E. Pumphrey, Inc., Silver Spring, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 15 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03364 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03357

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville (rural)
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Balto. Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville - 13 03 1
d. STREET ADDRESS: Old Balto. Rd
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

X

3. NAME OF DECEASED (Type or print): First: Maggie — Middle: Stanton — Last: Butler
4. DATE OF DEATH: Month: Mar — Day: 16 — Year: 1962
5. SEX: Fmale
6. COLOR OR RACE: Col
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 8-5-1868
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.C.
13. FATHER'S NAME: Harry Stanton
14. MOTHER'S MAIDEN NAME: Elizabeth Snowden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Della Welsh — Address: Item 2

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): hypertension — yrs,
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 3-16-62

2

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/20/62
22c. NAME OF CEMETERY OR CREMATORY: Friendship Methodist.,
22d. LOCATION (City, town, or country) (State): Damacus, Md.

23. FUNERAL DIRECTOR: Robert L. Swonde — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR: DATE MAR 22 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03365 Item 2 Film G309 03358

## CERTIFICATE OF DEATH

Item 14 Film G308 3/14/62 iwk 3/16/62 iwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: ~~Maryland~~
b. COUNTY: ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Silver Springs~~ Washington, D.C.
d. STREET ADDRESS: 35 Morrison St. N.W. ~~Beltway Nursing Home~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Norman Middle: Franklin Last: Butler

**4. DATE OF DEATH**: Month: March Day: 3 Year: 1962

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 5
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Photographer
11. BIRTHPLACE (County & State, or foreign country): Massachusetts
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Franklin Butler
14. MOTHER'S MAIDEN NAME: Augusta E. Buck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): None (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Washington Sanitarium and Hospital Records

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gangrenous cholecystitis — INTERVAL BETWEEN ONSET AND DEATH

5 8 5 X

~~DUE TO~~ (b) CIRRHOSIS OF LIVER

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): aneurysm of abdominal aorta

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ~~Mar~~ Feb 28, 1962 to Mar 3, 1962, that (I) (we) last saw the deceased alive on Mar 2, 1962, and that death occured at 2:35 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Leonard L. Deitz M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/5/62
22c. PHYSICIAN'S NAME (Type): LEONARD L. DEITZ
22d. ADDRESS: 800 PERSHING DR SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3/5/62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
23d. LOCATION (City, town or county) (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS: Felix J. Salerno 6103 Kingsley Ave N.W.
25a. REC'D BY REGISTRAR DATE MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03366

## CERTIFICATE OF DEATH

03359

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 22 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09 Rockville
d. STREET ADDRESS: 219 Highland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: BABY Middle: BOY Last: BUTT

**4. DATE OF DEATH** Month: March Day: 20 Year: 1962

**5. SEX**: MALE
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: 3/19/62
**9. AGE** (In years last birthday) yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.: 22

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): —
**10b. KIND OF BUSINESS OR INDUSTRY**: —
**11. BIRTHPLACE** (County & State, or foreign country): MARYLAND
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A

**13. FATHER'S NAME**: HARRY PRESTON BUTT
**14. MOTHER'S MAIDEN NAME**: BERNICE GEORGIA BURKE

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): —
(If yes give war or dates of service): —
**16. SOCIAL SECURITY NO.**: —
**17. INFORMANT**: MOTHER Address: (SAME AS ABOVE)

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH
761.5
DUE TO (b): Immaturity
DUE TO (c): Premature Separation of Placenta.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
**20c.** TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
**20d.** INJURY OCCURRED While at work ☐ Not While at work ☐
**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3/19, 1962, to 3/20, 1962, That (I) (we) last saw the deceased alive on 3/19, 1962, and that death occured at 12:07 AM, from the causes and on the date stated above.

**22a.** SIGNATURE: James S. Stanton M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b.** DATE SIGNED
**22c.** PHYSICIAN'S NAME (Type): JAMES S STANTON
**22d.** ADDRESS: 809 Viers Mill Rd Rockville Md

**23a.** BURIAL, CREMATION, REMOVAL (Specify): CREMATION
**23b.** DATE THEREOF: 3-21-62
**23c.** NAME OF CEMETERY OR CREMATORY: SUBURBAN HOSPITAL
**23d.** LOCATION (City, town or county) (State): BETHESDA, MD.

**24** FUNERAL DIRECTOR'S SIGNATURE: Amelia C. Carter, Admin. (per J.B.) ADDRESS: Suburban Hospital Bethesda, Md.
**25a.** REC'D BY REGISTRAR DATE: MAR 22 '62
**25b.** REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03367 **CERTIFICATE OF DEATH** 03360

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bella Vista Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. (D.C.)
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 1617.2
d. STREET ADDRESS: 1809 Owens Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Frances Middle: C. Last: Carroll
4. DATE OF DEATH: Month: March Day: 9 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-28-1892
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: School Teacher
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~[illegible]~~ Wm. Carroll
14. MOTHER'S MAIDEN NAME: Mary Alice ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Clarence Carroll - 1809 - Owens Rd Oxon Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Diabetes Mellitus — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 8, 1962 to March 9, 1962 that (I) (we) last saw the deceased alive on March 8 1962 and that death occured at 3:38 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip E. Jones, M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/9/62
22c. PHYSICIAN'S NAME (Type): Philip E. Jones
22d. ADDRESS: 918 Ellsworth Drive S.E. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar. 12-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland Md

24 FUNERAL DIRECTOR'S SIGNATURE: Simmons Bro.
ADDRESS: 1661 - Good Hope Rd SE Wash 20 DC
25a. REC'D BY REGISTRAR: DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03368 **CERTIFICATE OF DEATH** 03361

1 M

**1. PLACE OF DEATH** a. COUNTY: Montgomery, MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensingston,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Sant.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Mass. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Malden 58x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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**3. NAME OF DECEASED** (Type or print): First: EVA Middle: M Last: CARTER

**4. DATE OF DEATH** Month: MARCH Day: 19 Year: 1962

**5. SEX:** Female **6. COLOR OR RACE:** White **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH:** August 1, 1874

**9. AGE** (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY:**
**11. BIRTHPLACE** (County & State, or foreign country): Nova Scotia
**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Sylvias Mosher
**14. MOTHER'S MAIDEN NAME:** Eunice Dinsmore

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**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give were or dates of service): No
**16. SOCIAL SECURITY NO.:** 015-26-5480
**17. INFORMANT:** E.N. Read Address: 6905 Maple Ave. Chev. Ch., Md

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF MOUTH — INTERVAL BETWEEN ONSET AND DEATH:
144X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY
**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

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**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Nov. 29, 1969 to March 19, 1962 that (I) (we) last saw the deceased alive on March 19 1962 and that death occured at 4.45 A.M., from the causes and on the date stated above.

**22a. SIGNATURE** Benson Sowden M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED** 3/19/62
**22c. PHYSICIAN'S NAME** (Type)
**22d. ADDRESS** 5206 Norway Dr Chevy Chase, Md

1

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**23b. DATE THEREOF:** 3/21/62
**23c. NAME OF CEMETERY OR CREMATORY:** Puritan Lawn Mem. Pk.
**23d. LOCATION** (City, town or county) (State): West Peobody, Mass.

**24 FUNERAL DIRECTOR'S SIGNATURE** J. W. Rees **ADDRESS** Wash. D.C.
**25a. REC'D BY REGISTRAR** DATE MAR 22 '62
**25b. REGISTRAR'S SIGNATURE** Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03369 **CERTIFICATE OF DEATH** 03362

1 M 99

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): TAKOMA PARK, MD
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASHINGTON SANITARIUM & HOSP.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE, 1650-2
d. STREET ADDRESS: 5906 - 14TH. PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First JOHN Middle L. Last CASHELL

**4. DATE OF DEATH**: Month March Day 27 Year 1962

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Sept 1, 1910

**9. AGE** (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): ACCOUNTANT

**10b. KIND OF BUSINESS OR INDUSTRY**: U.S. GOV'T.

**11. BIRTHPLACE** (County & State, or foreign country): WASHINGTON, D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: HARRY M. CASHELL

**14. MOTHER'S MAIDEN NAME**: FANNIE L. LAVELL

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 577-22-3062

**17. INFORMANT**: Mrs. Irene M. Cashell — Address: Same as #2

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Insufficiency
DUE TO (b): Coronary Atherosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 430.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Previous Myocardial Infarction

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20e. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from Feb, 1956, to March 27, 1962, that (I) (~~we~~) last saw the deceased alive on March 27, 1962, and that death occured at 7:23 PM, from the causes and on the date stated above.

**22a. SIGNATURE**: Richard L. Whelton M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: March 27, 1962

**22c. PHYSICIAN'S NAME** (Type): RICHARD L. WHELTON

**22d. ADDRESS**: 1021 University Blvd E Silver Spring Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-31-62

**23c. NAME OF CEMETERY OR CREMATORY**: Mt Olivet Cemetery

**23d. LOCATION** (City, town or county) (State): Washington, D.C.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Francis J. Collins

**ADDRESS**: 3821-14th St. N.W. Wash. D.C.

**25a. REC'D BY REGISTRAR** DATE APR 2 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03370 **CERTIFICATE OF DEATH** 03363

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 54 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Ohio
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waverly
d. STREET ADDRESS: Route # 3, Box 377
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

72 X 3

**3. NAME OF DECEASED** (Type or print): First: Anna — Middle: Jane — Last: Cassady

**4. DATE OF DEATH**: Month: March — Day: 12 — Year: 19 62

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: January 2, 1924

**9. AGE** (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Baby Sitter

**10b. KIND OF BUSINESS OR INDUSTRY**: Domestic

**11. BIRTHPLACE** (County & State, or foreign country): Kentucky

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Rush Cassady

**14. MOTHER'S MAIDEN NAME**: Elma Bond

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give war or dates of service): Unascertainable

**17. INFORMANT**: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO (b) Congestive heart failure following operation: teflon graft anastomosis between left subclavian artery and left pulmonary artery
DUE TO (c) Corrected tranposition of great vessels with left-sided Ebstein's phenomenon and tetralogy of fallot and atrial septal defect

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 17 days

754.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
(c)(Cont.)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from January 17, 1962, to March 12, 1962, that (I) (we) last saw the deceased alive on March 12 1962, and that death occured at 5:20PM from the causes and on the date stated above.

**22a. SIGNATURE**: W B Berry M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: 3/13/62

**22c. PHYSICIAN'S NAME** (Type): W. B. Berry, M.D.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/15/62

**23c. NAME OF CEMETERY OR CREMATORY**: Cassady Cemetery

**23d. LOCATION** (City, town or county) (State): Inez, Kentucky

**24 FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 15 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03371 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03364

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASH SANT HOSP

**2. USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Silver SPRING
d. STREET ADDRESS: 2109 Dexter ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: HENRI Middle: Louis Last: Chamberland

**4. DATE OF DEATH** Month: 3 Day: 6 Year: 1962

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 2-23-10

**9. AGE** (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): ACCOUNTANT

**10b. KIND OF BUSINESS OR INDUSTRY**: NAVY Dept

**11. BIRTHPLACE** (State or foreign country): MASS.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A

**13. FATHER'S NAME**: ALEX CHAMBERLAND

**14. MOTHER'S MAIDEN NAME**: Josephine OUELLETTE

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unkown): Yes (If yes give war or dates of service): 2nd WW

**16. SOCIAL SECURITY NO.**: 579-40-9687

**17. INFORMANT**: ANN Chamberland Address: Same as Deceased

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME-OF INJURY** Month, Day, Year Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

MEDICAL CERTIFICATION

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

**ACTUAL SIGNATURE** Frank J. Broshart M.D.

**EXAMINER'S NAME** (Type) FRANK J. BROSHART

Address (Street, city, town, or county)

**DATE SIGNED** 3-7-62

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 3-10-62

**22c. NAME OF CEMETERY OR CREMATORY**: Gate of Heaven Cemetery

**22d. LOCATION** (City, town, or country) (State): Montgomery County Maryland

**23. FUNERAL DIRECTOR**: Francis J. Collin — ADDRESS: 3821-14th St. NW. Wash, D.C.

**24a. REC'D BY REGISTRAR** DATE: MAR 9 62

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03372 **CERTIFICATE OF DEATH** 03365

**1. PLACE OF DEATH**
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 9306 Flower Avenue

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Silver Spring
d. STREET ADDRESS: 9306 Flower Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Edith Middle: C Last: Childs

**4. DATE OF DEATH** Month: March Day: 9 Year: 19 62

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** Oct. 24, 1897

**9. AGE** (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:** own home

**11. BIRTHPLACE** (County & State, or foreign country): Louisiana

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Edward Cole

**14. MOTHER'S MAIDEN NAME:** Elizabeth Frances Eastman

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT** Address: Leroy M. Childs 9306 Flower Ave, Silver Spring Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH

527.1

DUE TO (b) Pulmonary Emphysema — 8 years

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 1951, 1951, to March 9, 1962, that (I) (~~we~~) last saw the deceased alive on March 5 1962, and that death occured at 1 A.M. from the causes and on the date stated above.

**22a. SIGNATURE** John W. Trenis M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ **22b. DATE SIGNED** 3-9-62

**22c. PHYSICIAN'S NAME** (Type) John W. Trenis

**22d. ADDRESS** 1150 Connecticutt Ave, N.W., Washington, D.C.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF:** 3-12-62

**23c. NAME OF CEMETERY OR CREMATORY:** St. John's Cemetery

**23d. LOCATION** (City, town or county) (State): Olney Montgomery Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** Raymond A. Zecker **ADDRESS** 8434 Georgia Ave Warner E. Pumphrey, Inc. Silver Spring, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 13 '62

**25b. REGISTRAR'S SIGNATURE** Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03373

# CERTIFICATE OF DEATH

Reg. Dist. No. 03366

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase Village
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 21 West Irving Street

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase Village, Sec. II
d. STREET ADDRESS: 21 West Irving Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Mary; Middle: Swingle; Last: Clark

**4. DATE OF DEATH**: Month: March; Day: 30; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: December 4, 1876

**9. AGE** (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House wife

**10b. KIND OF BUSINESS OR INDUSTRY**: None

**11. BIRTHPLACE** (State or foreign country): Washington, D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Robert Duncan Swingle

**14. MOTHER'S MAIDEN NAME**: Emma Catherine Johnston

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service): None

**16. SOCIAL SECURITY NO.**: None

**INFORMANT**: Charles C. Clark Jr. — Address: 403 Perry St., Fairfax, Va.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Cerebral arteriosclerosis — 3+ yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 10 DEC 1960 to 30 Mar. 1962 that I last saw the deceased alive on 28 Mar 1962 and that death occurred at 9:05 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: A.H. Richwine M.D. — ADDRESS (Street, city or town, state): 5522 Western Ave — DATE SIGNED: 31 MAR.

PHYSICIAN'S NAME (Type): A.H. RICHWINE, MD, Ch. Ch. 15, Md. 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/3/62

22c. NAME OF CEMETERY OR CREMATORY: Oak Hill

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland

24a. REC'D BY REGISTRAR: DATE APR 3 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03374 **CERTIFICATE OF DEATH** 03367

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4517 Willard Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Chevy Chase
d. STREET ADDRESS: 4517 Willard Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Addie; Middle:; Last: Constantine

4. DATE OF DEATH: Month: 3; Day: 11; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/10/78
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Gov't, Ret
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, DC
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Martin
14. MOTHER'S MAIDEN NAME: Olivia Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Fannie C. Scott-daughter-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO (b): GENERALIZED ARTERIOSCLEROSIS — 10 YRS
DUE TO (c): ADVANCING YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE, 1956 to MARCH, 1962, that (I) (we) last saw the deceased alive on 3/8 1962, and that death occured at 4P M, from the causes and on the date stated above.

22e. SIGNATURE: Leu I Donovan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/13/62
22c. PHYSICIAN'S NAME (Type): LEU I DONOVAN M.D
22d. ADDRESS: 8218 WISCONSIN AVE BETHLY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/13/62
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS:
25e. REC'D BY REGISTRAR DATE MAR 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03375

## CERTIFICATE OF DEATH

03368

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): BEL PRE NURSING HOME

**2. USUAL RESIDENCE** (Where deceased lived, if Institution: Residence before admission)
a. STATE: DISTRICT of COLUMBIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D.C. 47X-3
d. STREET ADDRESS: 2330 SKYLAND PL., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: IDA — Middle: E — Last: COOLEY

**4. DATE OF DEATH**: Month: MARCH — Day: 20 — Year: 1962

**5. SEX**: FEMALE
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☑
**8. DATE OF BIRTH**: AUGUST 11, 1896
**9. AGE** (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Dept. Store.
**10b. KIND OF BUSINESS OR INDUSTRY**: SALESLADY
**11. BIRTHPLACE** (County & State, or foreign country): WASHINGTON, D.C.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: William Z. Howard
**14. MOTHER'S MAIDEN NAME**: MARY SMITH

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO
(If yes give war or dates of service):
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT**: MR. RICHARD COOLEY, Address: 11333 Schykill, Rockv.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Cancer to Brain & Spinal Cord — INTERVAL BETWEEN ONSET AND DEATH: 8 Months
199X
DUE TO (b): Cancer, Primary Site Unknown Prob.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Kidney or Pancreas — 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 11/29, 1961, to 3/20, 1962, that (I) (we) last saw the deceased alive on 3/19 1962, and that death occured at 2:50 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Max G. Sherer M.D.
**22b. DATE SIGNED**
ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐
**22c. PHYSICIAN'S NAME** (Type): MAX G. SHERER, MD
**22d. ADDRESS**: 2025 EAST West H'way Silver Spring Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: Mar. 23-62
**23c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill Cemetery
**23d. LOCATION** (City, town or county) (State): Suitland Md

**24 FUNERAL DIRECTOR'S SIGNATURE**: Simmons Bros Funeral Home
ADDRESS: 1661 - Good Hope Rd SE WASH 20 DC
**25a. REC'D BY REGISTRAR** DATE: MAR 21 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. [illegible] be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 7/61

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03376 Item 4 Film 0309 3/19/62 jwk

## CERTIFICATE OF DEATH

03369

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 214 Frederick Ave.,

**2. USUAL RESIDENCE** (Where deceased lived, if institution, residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09 Rockville.,
d. STREET ADDRESS: 1 214 Frederick Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: MILOY Middle: C. Last: COOPER

**4. DATE OF DEATH** Month: March Day: 5, Year: 19 62

**5. SEX:** female

**6. COLOR OR RACE:** colored

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** Nov. 5, 1905

**9. AGE** (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired):

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?** U. S. A.

**13. FATHER'S NAME:** Henson Carroll

**14. MOTHER'S MAIDEN NAME:** Florence Hayes

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wars or dates of service):

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT:** Nelson Cooper Address: Item # 2

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month

443X

DUE TO (b) Arteriosclerotic hypertensive cardiovascular disease — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ~~DUE TO~~ (c) Left hemiplegia in 1957.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1957, 19, to March 5, 1962, that (I) (we) last saw the deceased alive on March 5 1962, and that death occured at 10:30 P.M., from the causes and on the date stated above.

**22a. SIGNATURE** Wm A. Lentlicum M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED** 3/6/62.

**22c. PHYSICIAN'S NAME** (Type) Wm A Lintlicum

**22d. ADDRESS** 110 S. Washington St. Rockville, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF:** 3-9-62

**23c. NAME OF CEMETERY OR CREMATORY:** St. Marys,

**23d. LOCATION** (City, town or county) (State): Rockville, Md

**24 FUNERAL DIRECTOR'S SIGNATURE:** Robert L. Sunder **ADDRESS:** Rockville, Md

**25a. REC'D BY REGISTRAR** DATE MAR 14 '62

**25b. REGISTRAR'S SIGNATURE** Chalmers S. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03377

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03370

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bellsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hunter Rd

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 05 Bellsville (rural)
d. STREET ADDRESS: Hunter Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

**3. NAME OF DECEASED** (Type or print): First: Pernell; Middle: ; Last: Cooper

**4. DATE OF DEATH**: Month: March; Day: 11; Year: 1962

**5. SEX**: male

**6. COLOR OR RACE**: col.

**7. MARRIED** [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

**8. DATE OF BIRTH**: 2/3/62

**9. AGE** (In years last birthday): yrs.; IF UNDER 1 YEAR: Months: 1; Days: 8; IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired):

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): Md.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Lewis Cooper

**14. MOTHER'S MAIDEN NAME**: Edith Harper

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Police Report — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
DUE TO (b) Upper Respiratory Infection
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

475 X

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES [ ] NO [X]

**20a. EXTERNAL CAUSE WAS** PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work [ ] Not While at work [ ]

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): Frank J. Broschart

Address (Street, city, town, or county):

DATE SIGNED: Mar. 11, 1962

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 3/14/62

**22c. NAME OF CEMETERY OR CREMATORY**: Elijah Church Cemetery

**22d. LOCATION** (City, town, or country) (State): Poolesville, Md.

**23. FUNERAL DIRECTOR**: Robert L. Snowden — ADDRESS: Rockville, Md.

**24a. REC'D BY REGISTRAR** DATE: MAR 15 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

2-028039

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03378 03371

1

FOR STATE HEALTH DEPT.

M 99 I

**1. PLACE OF DEATH** a. COUNTY: Montgomery County MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) e. STATE: D.C. b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X·3

d. STREET ADDRESS: 3154 Tennyson Street, N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Gail Middle: Walden Last: Crossen

**4. DATE OF DEATH** Month: 3/26/62 Day: Year: 19

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** 2/26/93

**9. AGE** (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): banker retired

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Ohio

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Daniel I. Crossen

**14. MOTHER'S MAIDEN NAME:** ~~Helen~~ Theresa Horn

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.:** Unknown

**17. INFORMANT:** Helen A. Crossen (wife) Address: Stem 2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

4-20-1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

MEDICAL CERTIFICATION

0

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschart

Address (Street, city, town, or county):

DATE SIGNED: 3-26-62

2

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF:** 3/29/62

**22c. NAME OF CEMETERY OR CREMATORY:** Rock Creek Cemetery

**22d. LOCATION** (City, town, or country) (State): Washington, D. C.

**23. FUNERAL DIRECTOR:** Robert A. Dumphrey ADDRESS: Bethesda, Maryland

**24a. REC'D BY REGISTRAR** DATE: MAR 30 '62

**24b. REGISTRAR'S SIGNATURE:** Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03379 03372

**1. PLACE OF DEATH**
a. COUNTY: ~~Maryland~~ Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4300 Glenrose St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen ~~Marie~~ Middle: Marie Last: Crossette
4. DATE OF DEATH: Month: March Day: 15, Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State, or foreign country): ~~W.~~ Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Pearce
14. MOTHER'S MAIDEN NAME: Clara White
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give were or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: George Crossette-Son-same 2d Address

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction, Antero-septal — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Coronary sclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3.9, 1962 to 3.15, 1962, that (I) (~~we~~) last saw the deceased alive on 3.14, 1962, and that death occured at 1.30 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Stewart Clapp M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3.15.62
22c. PHYSICIAN'S NAME (Type): Stewart Clapp MD
22d. ADDRESS: 4740 Chevy Chase Dr Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/19/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 16 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Mann

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03380

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13 & 14 Film 0309 3/22/62 jwk

03373

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Germantown (rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Violet Lock Rd.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 06 Germantown (rural)
d. STREET ADDRESS: Violet Lock Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Paul A. Middle: Czichos Last:

**4. DATE OF DEATH**: Month: Mar. Day: 9 Year: 1962

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

**8. DATE OF BIRTH**: 6/15/97

**9. AGE** (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Gov. service (retired)

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): ALVIN Texas

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Frank Czichos

**14. MOTHER'S MAIDEN NAME**: Rosa M. Plentl

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Yes (If yes give war or dates of service): WW I & 2

**16. SOCIAL SECURITY NO.**: 452 36 3531

**17. INFORMANT**: Police report Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

**ACTUAL SIGNATURE** Frank J. Broschart M.D.

**EXAMINER'S NAME** (Type) Frank J. Broschart. Gaithersburg Md.

**DATE SIGNED** Mar. 9, 1962

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 3-14-62

**22c. NAME OF CEMETERY OR CREMATORY**: Arlington National

**22d. LOCATION** (City, town, or country) (State): Arlington Va.

**23. FUNERAL DIRECTOR** ADDRESS: Ernest C. Gartner. Gaithersburg. Md.

**24a. REC'D BY REGISTRAR** DATE: MAR 15 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Thomas

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any c[illegible]s necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03381 Item 2 Film G308 3/12/62 iwk 03374

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Poolesville~~ / Silver Spring
d. STREET ADDRESS: 806 Wayne Avenue / ~~Matthews Home~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert; Middle: D; Last: Darby
4. DATE OF DEATH: Month: March; Day: 1; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 4 1869
9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: THOMAS DARBY
14. MOTHER'S MAIDEN NAME: ELIZABETH DAWSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (nephew) Address 806 Wayne Ave: Mr Gordon DARBY — Sil. Sp.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b): Myocardial Infarction
DUE TO (c): Senility

Conditions, if any, which geva rise to immediate ceuse (a), steting the underlying ceuse lest.

4 2 2 2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 9, 1958 to Mar 1, 1962, that (I) (we) last saw the deceased alive on Mar 1 1962 and that death occured at 9:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Oliver E. Thompson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-1-62
22c. PHYSICIAN'S NAME (Type): Dr. Oliver Thompson
22d. ADDRESS: 901 Pershing Dr Silver Sp.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/3/62
23c. NAME OF CEMETERY OR CREMATORY: Monocacy
23d. LOCATION (City, town or county) (State): Beallsville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: William E. Hilton — ADDRESS: Barnesville, Md.
25a. REC'D BY REGISTRAR — DATE MAR 6 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Travers

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03382 **CERTIFICATE OF DEATH** 03375

Item 9 Film G311 4/12/62 mh

**1. PLACE OF DEATH** a. COUNTY ~~Prince George~~ Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7807 Garland Ave

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) a. STATE: Md b. COUNTY: ~~Pr. George~~ Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Takoma Park

d. STREET ADDRESS: 7807 Garland Ave.

a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Annie Middle: M Last: Darne

**4. DATE OF DEATH** Month: March Day: 18, Year: 1962

**5. SEX:** Female **6. COLOR OR RACE:** White **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** March 22, 1878 **9. AGE** (In years last birthday): 83 3/4 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): At home **10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (County & State, or foreign country): Maryalnd **12. CITIZEN OF WHAT COUNTRY?** U.S.

**13. FATHER'S NAME:** Thomas W Webster **14. MOTHER'S MAIDEN NAME:** Eliza Burrus

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no (If yes give year or dates of service):

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT** Address: Eppa W Darne - same as above.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO (b) Coronary insufficiency — 4 yrs.

DUE TO (c) Coronary arteri-sclerosis — 15 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 28, 1962, to March 18, 1962, that (I) (we) last saw the deceased alive on 3/17, 1962, and that death occured at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Walter K Angevine M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Walter K Angevine

22d. ADDRESS: 6300 - 13th St, NW, Wash. 11, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-20-62

23c. NAME OF CEMETERY OR CREMATORY: Congressional

23d. LOCATION (City, town or county) (State): Washington D.C.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lee Funeral Home - Washington D.C.

25a. REC'D BY REGISTRAR DATE MAR 22 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Mills

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03383 **CERTIFICATE OF DEATH** 03376

1. **PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 189 days,
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: D. C. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 950 25th Street NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mary Middle: Jeanette Last: Davis

4. **DATE OF DEATH** Month: March Day: 19 Year: 62

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 3,1903
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Washington, D, C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Sullivan
14. MOTHER'S MAIDEN NAME: Nettie C. Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): - - - -
16. SOCIAL SECURITY NO.:
17. **INFORMANT** Address: Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of hypopharynx — INTERVAL BETWEEN ONSET AND DEATH

14 7X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from Sept. 11, 1961, to March 19, 1962 that I (we) last saw the deceased alive on March 19, 1962, and that death occured at 1:00AM from the causes and on the date stated above.

22a. SIGNATURE: William C Monell M.D.
22b. DATE SIGNED: March 19, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): WILLIAM C. MONELL LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 22 March 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: DEVOL Funeral Home, 2224 Wisc. Ave., Wash., D. C.
25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Carlton L. Hume

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

Item 18 Film 309 3-21-62

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03384 03377

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 30 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 36 Kensington
d. STREET ADDRESS: 3112 McComas Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Argent; Middle: Elaine; Last: Denniston

**4. DATE OF DEATH**: Month: March; Day: 14; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 25 November 1959

**9. AGE** (In years last birthday): 2 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): child

**10b. KIND OF BUSINESS OR INDUSTRY**: None

**11. BIRTHPLACE** (County & State, or foreign country): South Carolina

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Charles L. Denniston, Jr.

**14. MOTHER'S MAIDEN NAME**: Rosemary Brown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give year or dates of service)

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiorespiratory Failure — INTERVAL BETWEEN ONSET AND DEATH
204.3
DUE TO (b) Acute Myelocytic Leukemia — 7 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Feb. 12, 1962 to March 14, 1962, that (I) (we) last saw the deceased alive on March 14, 1962, and that death occured at 1:45PM, from the causes and on the date stated above.

**22a. SIGNATURE**: Geo. H. Porter, III MD M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22b. DATE SIGNED**: 3-14-62

**22c. PHYSICIAN'S NAME** (Type): George H. Porter M.D.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda, 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/15/62

**23c. NAME OF CEMETERY OR CREMATORY**

**23d. LOCATION** (City, town or county) (State): Columbia, D.C.

**24 FUNERAL DIRECTOR'S SIGNATURE**: W. W. Chambers Co.
ADDRESS: 1400 Rhode Island Ave. Washington D.C.

**25a. REC'D BY REGISTRAR** DATE: MAR 16 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03385

## CERTIFICATE OF DEATH

Reg. Dist. No. 03378

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 55 Chevy Chase
d. STREET ADDRESS: 5819 Highland Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: J. Middle: EDWARD Last: DOMKE

**4. DATE OF DEATH**: Month: MARCH Day: 11 Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 4/4/68

**9. AGE** (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months: 11 Days: 7
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Salesman-retired

**10b. KIND OF BUSINESS OR INDUSTRY**: Selling

**11. BIRTHPLACE** (State or foreign country): Wisconsin

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Unknown

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**: 470-12-8447

**INFORMANT**: Adelaide W. Domke-wife-same above
Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF INTESTINES
DUE TO
(b) CARCINOMA OF PROSTATE
DUE TO
(c) GENERALIZED ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year: Hour a. m. p. m. 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from JAN. 15, 1962 to MARCH 11, 1962 that I last saw the deceased alive on MARCH 11, 1962 and that death occurred at 8.45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry M. Lowden M.D.
ADDRESS (Street, city or town, state): 5206 Norway Dr. Chevy Chase, Md.
DATE SIGNED: 3/11/62

PHYSICIAN'S NAME (Type): Henry M. Lowden 5206 Norway Drive, Chevy Chase, Md.

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Cremation

**22b. DATE THEREOF**: 3/12/62

**22c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill Crematory

**22d. LOCATION** (City, town, or county) (State): Suitland, Maryland

**23. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**24a. REC'D BY REGISTRAR** DATE: MAR 14 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Travers

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03386 **CERTIFICATE OF DEATH** 03379

Item 8 & 23b, Film G309 3/22/62 jwk

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. NAVAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
e. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 3500 Neward St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Benjamin; Middle: Henry; Last: Dorsey

4. **DATE OF DEATH**: Month: March; Day: 17; Year: 1962

5. SEX: Male
6. COLOR OR RACE: Caucasion
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 13, 1877 (1877)
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Naval Officer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joshua W. Dorsey
14. MOTHER'S MAIDEN NAME: Elenor E. Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. **INFORMANT** Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, Lobar
DUE TO (b) Intestinal obstruction, Cause unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

570.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 21 1962 to Mar 17 1962, that (I) (we) last saw the deceased alive on 17 March 1962, and that death occured at 4:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. F. Warrender M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 18 March 1962
22c. PHYSICIAN'S NAME (Type): W.F. WARRENDER
22d. ADDRESS: U.S. NAVAL HOSPITAL, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 21, 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: JOSEPH GAWLER'S SONS INC. 1756 Pennsylvania Ave N.W. Washington D.C.
25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Flaura

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03387 **CERTIFICATE OF DEATH** 03380

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 9916 Old Spring Road

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 41 Kensington
d. STREET ADDRESS: 9916 Old Spring Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Madeline — Middle: G — Last: DRISCOLL
4. DATE OF DEATH: Month: March — Day: 5, — Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 30, 1885
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months 5 Days 5 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Peter P. Spiells
14. MOTHER'S MAIDEN NAME: (Unknown) Lyman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Henry Campbell-daughter-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO (b) Arteriosclerotic Heart Disease — Unknown
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/12, 1958 to 3/5, 1962, that (I) (we) last saw the deceased alive on 4 March 1962 and that death occured at 4:19 P.M. from the causes and on the date stated above.

22e. SIGNATURE: George Sharpe M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/5/62
22c. PHYSICIAN'S NAME (Type): George Sharpe
22d. ADDRESS: 10511 Summit Ave., Kensington, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 3/8/62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
23d. LOCATION (City, town or county) (State): Boise, Idaho

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25e. REC'D BY REGISTRAR — DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03388

## CERTIFICATE OF DEATH

Reg. Dist. No. 03381

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 Silver Spring
d. STREET ADDRESS: 1304 Dale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: REGINA — Middle: M. — Last: DUGAN

**4. DATE OF DEATH**: Month: March — Day: 12 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: May 21, 1906

**9. AGE** (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): Md.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Frank Graebenstein

**14. MOTHER'S MAIDEN NAME**: AnnaM. Brady

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Mr. John J. Dugan — Address: 1304 Dale Drive, Silver Spring, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic renal insufficiency - one kidney removed a year and a half ago

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a. m. p. m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

21. I **certify** that I attended the deceased from September 4 1956, to 3/12, 1962, that I last saw the deceased alive on 3/12, 1962, and that death occurred at 11:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward J Paccione M.D. — ADDRESS (Street, city or town, state): 1746 K St. N.W. — DATE SIGNED: 3/12/62

PHYSICIAN'S NAME (Type):

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 3/15/62

**22c. NAME OF CEMETERY OR CREMATORY**: Mt. Olivet Cemetery

**22d. LOCATION** (City, town, or county) (State): Washington, D.C.

**23. FUNERAL DIRECTOR'S SIGNATURE**: Chaney Funeral Home By J. Paul Pettis — ADDRESS: 5102 Kansas Ave N.W. Wash. D.C.

**24a. REC'D BY REGISTRAR** DATE: MAR 15 '62

**24b. REGISTRAR'S SIGNATURE**: Carlton S. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03389

# CERTIFICATE OF DEATH

03382

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda — c. LENGTH OF STAY IN 1b: 9 Yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5721 Grosvenor Lane Resmor San & Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

d. STREET ADDRESS: 6203-Bannockburn Drive — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: John — Middle: Moyle — Last: Duncan

**4. DATE OF DEATH**: Month: March — Day: 10 — Year: 19 62

**5. SEX**: Male — **6. COLOR OR RACE**: White — **7. MARRIED** ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

**8. DATE OF BIRTH**: 9-25-1889 — **9. AGE** (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Engineer — **10b. KIND OF BUSINESS OR INDUSTRY**: Gov,t — **11. BIRTHPLACE** (County & State, or foreign country): Toronto Canada — **12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John T. Duncan — **14. MOTHER'S MAIDEN NAME**: Alice Lukes

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: 227-07-3114 — **17. INFORMANT**: Alice E. Duncan — Address: Bethesda, Md. 4705-Bradley Blvd.

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General sepsis — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

DUE TO (b) Decubital ulcers — 5 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cerebral a generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hip fracture, rgt

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept, 1961, to Mar, 1962, that (I) (we) last saw the deceased alive on 3-9 1962 and that death occured at 12:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Dorothy Gill, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 3/10/62

22c. PHYSICIAN'S NAME (Type): Dorothy Gill, M.D. — 22d. ADDRESS: 7511 Arlington Rd., Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 23b. DATE THEREOF: 3/10/62 — 23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory — 23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co. — ADDRESS: 2901 14th Street, N.W. Washington 9, D.C.

25a. REC'D BY REGISTRAR DATE: MAR 12 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

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2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03390

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03383

1. PLACE OF DEATH
a. COUNTY Mont — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 7 hrs. 30 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
d. STREET ADDRESS 4614 - Hunt Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Pearl Middle: C. Last: Tunsmore
4. DATE OF DEATH Month: March Day: 1 Year: 1962
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3/27/86
9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary (ret) Govt.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James A. Conner
14. MOTHER'S MAIDEN NAME Belle Powell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Arthur E. Tunsmore / Son — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO (b) Coronary thrombosis
DUE TO (c) Coronary arteriosclerosis

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8 hr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture of skull

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fall on concrete driveway at home
20c. TIME OF INJURY Hour 2:00 a.m. p.m. Month, Day, Year 3-1 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Chevy Chase (County) Montg (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) FRANK J. Broschart
Address (Street, city, town, or county)
DATE SIGNED Mar 2-1962

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/5/1962
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park
22d. LOCATION (City, town, or country) Falls Church, Virginia (State)

23. FUNERAL DIRECTOR J. H. Hines Co.
ADDRESS 2901 14th St. N.W.
24a. REC'D BY REGISTRAR DATE MAR 5 '62
24b. REGISTRAR'S SIGNATURE Arthur L. Hines

Items 18&21 Film 309 3[illegible]

1
FOR STATE HEALTH DEPT.

**IO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**IO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

03391

# MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03384

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN (b): 12 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 612 McNeill Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 612 McNeill Rd
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Vincent Middle: L. Last: Eaton
4. DATE OF DEATH: Month: Mar Day: 16 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8-31-15
9. AGE (In years last birthday): 44 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Publication Offic
10b. KIND OF BUSINESS OR INDUSTRY: Lib of Congress
11. BIRTHPLACE (State or foreign country): Venezuela
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Evan W. Eaton
14. MOTHER'S MAIDEN NAME: Inez Lanius
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dorothy Eaton (wife) Address: Highlands apts Conn. Ave - DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Barbiturate poisoning — INTERVAL BETWEEN ONSET AND DEATH: ?
871.9
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 3-17-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3-17-62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or country) (State): Prince George's Co. Maryland

23. FUNERAL DIRECTOR: Raymond A. Ziska ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 20 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03392 03385

**1. PLACE OF DEATH**
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 9514 Kentstone Drive

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 45 Bethesda
d. STREET ADDRESS: 9514 Kentstone Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mattie; Middle:; Last: Edwards
4. DATE OF DEATH: Month: March; Day: 23; Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 31, 1887
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months 7, Days 22 IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife-US Govt
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New Hampshire
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred C. Horner
14. MOTHER'S MAIDEN NAME: Barbars MacKenzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: William Byrns-Cousin- Address: New Hampshire

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC Ca. LUNG; PELVIS AND — INTERVAL BETWEEN ONSET AND DEATH
1915 ~~DUE TO~~ LIVER
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) EPIDERMOID Ca. ABDOMINAL WALL — 2 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from FEB., 1962 to MARCH 23, 1962, that (I) (~~we~~) last saw the deceased alive on MARCH 19 1962, and that death occured at 12:40 p.m. from the causes and on the date stated above.

22a. SIGNATURE: J. Blaine Fitzgerald M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-23-62
22c. PHYSICIAN'S NAME (Type): J. Blaine Fitzgerald
22d. ADDRESS: 8218 WISCONSIN AVE. BETHESDA.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/26/62
23c. NAME OF CEMETERY OR CREMATORY: Wash. Nat. Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03393

## CERTIFICATE OF DEATH

03386

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 44 Bethesda
d. STREET ADDRESS: 1 5329 Pooks Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Alan — Middle: E. — Last: Evelyn

**4. DATE OF DEATH**: Month: March — Day: 3, — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 8/14/86

**9. AGE** (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY**: Telephone Co.

**11. BIRTHPLACE** (County & State, or foreign country): British West Indies

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John Evelyn

**14. MOTHER'S MAIDEN NAME**: Mary New

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No. (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: Yes-Unknown

**17. INFORMANT**: Same as above. Address: Rose Evelyn, Wife

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Thrombophlebitis of RT. Arm c̄ EMBOLI TO BRAIN & LUNG — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(b) RADIATION FIBROSIS OF AXILLA + LYMPADEMA OF RT. ARM — 18 Months.
DUE TO
(c) LYMPHOSARCOMA — 6 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY**: Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1949 to MARCH 3, 1962, that (I) (we) last saw the deceased alive on MARCH 2, 1962, and that death occured at 8:45 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: William Frank M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/3/62

**22c. PHYSICIAN'S NAME** (Type): WILLIAM FRANK, M.D.

**22d. ADDRESS**: 544 W. MONTGOMERY ROCKVILLE, Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/6/62

**23c. NAME OF CEMETERY OR CREMATORY**: Parklawn Cemetery

**23d. LOCATION** (City, town or county) (State): Rockville, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 7 '62

**25b. REGISTRAR'S SIGNATURE**: Corinne S. Hines

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03394 **CERTIFICATE OF DEATH** 03387

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland 1620-2
d. STREET ADDRESS: 4738 Homer Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Agnes; Last: Ezzell
4. DATE OF DEATH: Month: March; Day: 24; Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 12, 1885
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Flinn
14. MOTHER'S MAIDEN NAME: Rose Lee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: Not available
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mycosis fungoides

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from March 5, 1962, to March 24, 19.62 that I (we) last saw the deceased alive on March 24, 19.62, and that death occured at 2:35 PM, from the causes end on the date stated above.

22a. SIGNATURE: Geo. H. Porter M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 24, 1962
22c. PHYSICIAN'S NAME (Type): George H. Porter III, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 27-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros — ADDRESS: 1661 - 9th Hoped Road SE
25a. REC'D BY REGISTRAR — DATE: MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G310 4/5/62 mh

03395

## CERTIFICATE OF DEATH

Reg. Dist. No. 03388

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEHEATONY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BEL PRE NURSING HOME

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING 31
d. STREET ADDRESS: 309 DENNIS AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Bertha — Middle: — Last: Feldesman

**4. DATE OF DEATH**: Month: 3 — Day: 30 — Year: 1962

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

**8. DATE OF BIRTH**: APRIL 15, 1883

**9. AGE** (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HW

**10b. KIND OF BUSINESS OR INDUSTRY**: —

**11. BIRTHPLACE** (State or foreign country): ROUMANIA

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: JACOB SMILOWITZ

**14. MOTHER'S MAIDEN NAME**: RACHEL BERESOV

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): — (If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**: —

**INFORMANT**: DR JACKSON FELDESMAN — Address: 309 DENNIS AVE SOM

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Cerebral Arteriosclerosis — 5 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a. m. p. m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from 1947, 19__, to 3/30, 1962, that I last saw the deceased alive on 3/29, 1962, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

**ACTUAL SIGNATURE**: Irving W. Winik M.D. — **ADDRESS** (Street, city or town, state): 3900 McKinley St. N.W. Washington 15, DC — **DATE SIGNED**: 3/30/62

**PHYSICIAN'S NAME** (Type): Irving W. Winik

**22a. BURIAL, CREMATION, REMOVAL** (Specify): APRIL 1, 1962

**22b. DATE THEREOF**:

**22c. NAME OF CEMETERY OR CREMATORY**: MT LEBANON CEMETERY

**22d. LOCATION** (City, town, or county) (State): QUEENS N.Y.

**23. FUNERAL DIRECTOR'S SIGNATURE**: B Kangsuelly & Son — **ADDRESS**: 3501-14 ST. N.W.

**24a. REC'D BY REGISTRAR** — DATE: APR 3 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Kane

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03396 **CERTIFICATE OF DEATH** 03389

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery, MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 800 Midland Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 Silver Spring
d. STREET ADDRESS: 1 800 Midland Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Susan Middle: Murphy Last: Ferguson

4. DATE OF DEATH: Month: Mar Day: 15 Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 23, 1902.
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Goldsboro N.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Murphey
14. MOTHER'S MAIDEN NAME: Annie Patrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Robert G. Hires, Address: 800 Midland Rd. Sil Spg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum — INTERVAL BETWEEN ONSET AND DEATH: 2 years

154X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 23 Dec 1961, to 15 Mar 1962, that (I) (we) last saw the deceased alive on 12 Mar 1962, and that death occured at 7 A.M. from the causes and on the date stated above.

22a. SIGNATURE: H B Queen M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 15 Mar 1962
22c. PHYSICIAN'S NAME (Type): H. B. Queen
22d. ADDRESS: 7112 Willow Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Mar 17, 1962
23c. NAME OF CEMETERY OR CREMATORY: Willowdale Cem.
23d. LOCATION (City, town or county) (State): Goldsboro N.Car.

24. FUNERAL DIRECTOR'S SIGNATURE: Walker Walker ADDRESS: 254 Carroll St N.W. WASH 12 D.C.
25a. REC'D BY REGISTRAR DATE: MAR 16 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03397

## CERTIFICATE OF DEATH

03390

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4½ hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: Route 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

**3. NAME OF DECEASED** (Type or print): First: Sally; Middle: M.; Last: Fitzell

**4. DATE OF DEATH**: Month: March; Day: 19; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 7/1/23
9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months 8, Days 18 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (County & State, or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Stewart
14. MOTHER'S MAIDEN NAME: Mary Garrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: ~~None~~
17. INFORMANT: Walter C. Fitzell — Address: Same As Above.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 dy
DUE TO (b) Pulmonary Metastases — 1 mos
DUE TO (c) Carcinoma of the Pancreas — 8 mos

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 1962 to March 19, 1962, that (I) (we) last saw the deceased alive on March 19, 1962, and that death occured at 4:59 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William Henry Killay M.D.
ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 3/19/62
22c. PHYSICIAN'S NAME (Type): William H. Killay
22d. ADDRESS: 8218 Wisconsin Ave Bethesda.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/22/62
23c. NAME OF CEMETERY OR CREMATORY: St. John Church Cem.
23d. LOCATION (City, town or county) (State): Kingsville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03398

## CERTIFICATE OF DEATH

03391

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Silver Spring
d. STREET ADDRESS: 816 Patton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Esther — Middle: L — Last: Fleming

**4. DATE OF DEATH**: Month: March — Day: 1 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: March 23, 1894

**9. AGE** (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Clerk

**10b. KIND OF BUSINESS OR INDUSTRY**: Retired-So. R. R.

**11. BIRTHPLACE** (County & State, or foreign country): New Hampshire

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: William H. Wright

**14. MOTHER'S MAIDEN NAME**: Emma Davis

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give were or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Florence F. Crawford — Address: 816 Patton Dr.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma rectosigmoid with metastases
DUE TO (b): To liver, lungs & brain
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.): NONE

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from July, 1959 to March 1, 1962 that (I) (we) last saw the deceased alive on March 1, 1962, and that death occured at 1:05 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: James R. Goodson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**:
**22c. PHYSICIAN'S NAME** (Type): James R. Goodson
**22d. ADDRESS**: 1746 K ST N.W. Washington D.C.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-5-62
**23c. NAME OF CEMETERY OR CREMATORY**: Fort Lincoln Cemetery
**23d. LOCATION** (City, town or county) (State): Bladensburg Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE**: Deal Funeral Home
ADDRESS: 4812 Ga.Ave.,N.W.,Wash.DC
**25a. REC'D BY REGISTRAR** DATE MAR 8 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03399

## CERTIFICATE OF DEATH

03392

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wilmington
d. STREET ADDRESS: 118 Ruth Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evelyn; Middle: (None); Last: Ford

4. DATE OF DEATH: Month: March; Day: 2; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 10, 1901
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafeteria worker
10b. KIND OF BUSINESS OR INDUSTRY: Cafeteria
11. BIRTHPLACE (County & State, or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James R. Lockerman
14. MOTHER'S MAIDEN NAME: Mary Hadley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 221-12-6401
17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mycosis fungoides — INTERVAL BETWEEN ONSET AND DEATH: 8 years
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

20 SX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 10, 1962, to March 2, 1962 that (I) (we) last saw the deceased alive on March 2, 1962, and that death occured at 3:00 AM from the causes and on the date stated above.

22a. SIGNATURE: Geo. H. Porter, III M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3/2/62
22c. PHYSICIAN'S NAME (Type): George H. Porter, III, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-6-62
23c. NAME OF CEMETERY OR CREMATORY: Silver Brook
23d. LOCATION (City, town or county) (State): Wilmington Del.

24 FUNERAL DIRECTOR'S SIGNATURE: Neal Funeral Home
ADDRESS: 4812 Ga. Ave. Wash. D.C
25a. RECEIVED BY REGISTRAR
DATE: MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Andrew S. Krema

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03400 **CERTIFICATE OF DEATH** 03393

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville 09
d. STREET ADDRESS: 1218 Rockville Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Forrest; Middle: (No middle Name); Last: Ford, Jr.
4. DATE OF DEATH: Month: March; Day: 29; Year: 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3 March 1899
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Industrial Equipment Operator
10b. KIND OF BUSINESS OR INDUSTRY: Fed. Government
11. BIRTHPLACE (County & State, or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Forrest Ford, Sr.
14. MOTHER'S MAIDEN NAME: Dora Graham
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Not available
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: undetermined
DUE TO (b) Arteriosclerotic heart disease with coronary occlusion
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 29, 1962 to March 29, 1962, that (I) (we) last saw the deceased alive on March 29 1962, and that death occured at 8:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: David Horwitz M.D.
22b. DATE SIGNED: 3/29/62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): David Horwitz, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 4/2/62
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park
23d. LOCATION (City, town or county) (State): Dayton, Ohio

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

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FOR STATE HEALTH DEPT.

M

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TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03401 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03394

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 30min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San & Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 24 Silver Springs
d. STREET ADDRESS: 824 Violet Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Floyd — Middle: Merl — Last: Foster

**4. DATE OF DEATH**: Month: 3 — Day: 8 — Year: 1962

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 10-14-1884

**9. AGE** (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Machinist

**10b. KIND OF BUSINESS OR INDUSTRY**: Naval Gun Factory

**11. BIRTHPLACE** (State or foreign country): Pennsylvania

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: Foster

**14. MOTHER'S MAIDEN NAME**: Ammanda Tarr

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no — (If yes give wars or dates of service)

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Mrs. Elsie M. Foster, (same as #2) — Address

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Mar 8 1962

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Entombment
**22b. DATE THEREOF**: March 12. 1962
**22c. NAME OF CEMETERY OR CREMATORY**: ~~Fort Lincoln Mausoleum~~ Columbia Gardens
**22d. LOCATION** (City, town, or county): Prince Georges County, (State): Maryland

**23. FUNERAL DIRECTOR**: Arthur Walters — ADDRESS: 254 Carroll St. N.W. Wash. D.C.
**24a. REC'D BY REGISTRAR** DATE: MAR 12 '62
**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03402

## CERTIFICATE OF DEATH

03395

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria — 83X-3
d. STREET ADDRESS: 603 Ferry Landing Rd.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Winfield — Middle: Stover — Last: FRANCIS

**4. DATE OF DEATH**: Month: March — Day: 17 — Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: Cauc
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: 12-22-33
**9. AGE** (In years last birthday): 28 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired):
**10b. KIND OF BUSINESS OR INDUSTRY**:
**11. BIRTHPLACE** (County & State, or foreign country): Pennsylvania
**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Henry Watson Stover
**14. MOTHER'S MAIDEN NAME**: Dorothy Armstrong

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service):
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT**: HUS: Evans J. Francis — Address: Same As #2

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sarcoma, unclassified — INTERVAL BETWEEN ONSET AND DEATH
199X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**2Da. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**2Db. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**2Dd. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 13, 1962, to March 17, 1962, that (I) (we) last saw the deceased alive on March 17 1962, and that death occured at 12:45 AM from the causes and on the date stated above.

**22a. SIGNATURE**: Benjamin J. Gilson M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22b. DATE SIGNED**: 17 March 1962
**22c. PHYSICIAN'S NAME** (Type): Benjamin J. Gilson, LT MC USN
**22d. ADDRESS**: U.S. Naval Hospital, Bethesda, Maryland

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-20-62
**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National
**23d. LOCATION** (City, town or county) (State): Arlington, Virginia

**24 FUNERAL DIRECTOR'S SIGNATURE**: M B Quell
**ADDRESS**: Everly-Wheatley Funeral Home, Alexandria, Virginia, 1500 W. Braddock Rd.
**25a. REC'D BY REGISTRAR** DATE: MAR 20 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Krause

VR A1S (4)
1SM 7/61

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M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03403

## CERTIFICATE OF DEATH

03396

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b: 30 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): BELPRE Nursing + Convu. Home, Inc

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 076 GAITHERSBURG, Md.
d. STREET ADDRESS: 10 WALKER AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

**3. NAME OF DECEASED** (Type or print): First: William — Middle: P. — Last: FRANK

**4. DATE OF DEATH**: Month: 3 — Day: 24 — Year: 1962

**5. SEX**: MALE

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 4-8-1883

**9. AGE** (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Carpenter

**10b. KIND OF BUSINESS OR INDUSTRY**: Gen. Construction

**11. BIRTHPLACE** (County & State, or foreign country): OHIO

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: Unknown

**14. MOTHER'S MAIDEN NAME**: Unknown

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**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: unknown

**17. INFORMANT**: Fannie E, Frank — Address: Same as 2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebrovascular Thrombosis | 1 week |
| DUE TO (b) | Cerebral Arteriosclerosis | Several years |
| DUE TO (c) | Generalized Arteriosclerosis | Several years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

3332

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Emphysema

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

**20d.** INJURY OCCURRED: While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

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**21. I certify** that (I) (this hospital) attended the deceased from 1/27/62, 19__, to 3/23, 1962, that (I) (we) last saw the deceased alive on 3/23 1962, and that death occured at 2:45 A.M., from the causes and on the date stated above.

**22a.** SIGNATURE: Max G. Sherer MD — M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

**22b.** DATE SIGNED: 3/24/62

**22c.** PHYSICIAN'S NAME (Type): MAX G. SHERER, MD

**22d.** ADDRESS: 2025 EAST West H'way Silver Spring Md

1

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial

**23b.** DATE THEREOF: March 27 1961

**23c.** NAME OF CEMETERY OR CREMATORY: Laytonsville

**23d.** LOCATION (City, town or county) (State): Laytonsville Md.

**24** FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.

**25a.** REC'D BY REGISTRAR DATE: MAR 28 '62

**25b.** REGISTRAR'S SIGNATURE: Arthur S. Travis

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03404 **CERTIFICATE OF DEATH** 03397

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DEL PRE NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47X3
d. STREET ADDRESS: 4500 CONN. AVE N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: PHILIP [redacted] Middle: Last: FRANKS

4. DATE OF DEATH: Month: 3 Day: 7 Year: 1962

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY-31-1902
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JEWELER
10b. KIND OF BUSINESS OR INDUSTRY: –
11. BIRTHPLACE (County & State, or foreign country): LONDON. ENGLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MAX FRANKS
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wars or dates of service): –
16. SOCIAL SECURITY NO.: 577-40-7466
17. INFORMANT: LILY FRANKS Address: 4500 CONN. AVE. N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL Metastases
DUE TO (b): CANCER of the LUNG
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

163 X

INTERVAL BETWEEN ONSET AND DEATH: 3 Months / 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Metastatic Disease to other portions of Lungs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 28 1961, to March 7, 1962, that (I) (we) last saw the deceased alive on March 7 1962, and that death occured at 4:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Max G. Sherer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐
22b. DATE SIGNED: 3/7/62
22c. PHYSICIAN'S NAME (Type): MAX G. SHERER MD
22d. ADDRESS: 2027 Eye Street NW Washington, DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/11/62
23c. NAME OF CEMETERY OR CREMATORY: NAT'L MEM. PARK
23d. LOCATION (City, town or county) (State): FALLS CHURCH VA.

24. FUNERAL DIRECTOR'S SIGNATURE: Hickey Funeral Home
ADDRESS: 1717-9th St NW
25a. REC'D BY REGISTRAR DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Nunn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed [redacted] 24 hours after death. [redacted] retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03405

## CERTIFICATE OF DEATH

03398

M

50

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN fb: 34
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edinburg
d. STREET ADDRESS: Route #2, Box 66
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

83 x 3

**3. NAME OF DECEASED** (Type or print): First: Ronald; Middle: Pennywitt; Last: Funkhouser

**4. DATE OF DEATH**: Month: March; Day: 7; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: August 19, 1940

**9. AGE** (In years last birthday): 21 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Student

**10b. KIND OF BUSINESS OR INDUSTRY**: Not employed

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: S. Alvin Funkhouser

**14. MOTHER'S MAIDEN NAME**: Louise Kagey

I

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: Not available

**17. INFORMANT**: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terato-choriocarcinoma of left testis with carcinomatosis.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 months

1 78 X

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

1

**21. I certify** that ☒ (this hospital) attended the deceased from February 1, 1962 to March 7, 1962 that (☒ (we) last saw the deceased alive on March 7, 1962, and that death occured at 5:30 AM from the causes and on the date stated above.

**22a. SIGNATURE**: Geo. H. Porter III, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: 3-6-62

**22c. PHYSICIAN'S NAME** (Type): George H. Porter, III, M.D.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-10-62

**23c. NAME OF CEMETERY OR CREMATORY**: Bethel

**23d. LOCATION** (City, town or county) (State): Edinburg Va.

**24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Lee Funeral Home washington D.C.

**25a. REC'D BY REGISTRAR** DATE: MAR 9 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 is retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03406

## CERTIFICATE OF DEATH

Item 23b, Film G309 5/29/62 iwk

Item 8 Film G310 4/2/62 MM

03399

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Portsmouth
d. STREET ADDRESS: 918 North Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

83 X 3

51

**3. NAME OF DECEASED** (Type or print): First: Eugene; Middle: Franklin; Last: Gayle Jr.

**4. DATE OF DEATH**: Month: March; Day: 23; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: ~~March~~ April 14, 1941

**9. AGE** (In years last birthday): 21 yrs.

IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Service Man

**10b. KIND OF BUSINESS OR INDUSTRY**: - - - - -

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Eugene F. Gayle

**14. MOTHER'S MAIDEN NAME**: Ruth E. Swain

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Ues

(If yes give year or dates of service): No

**16. SOCIAL SECURITY NO.**: - - - -

**17. INFORMANT**: Hospital Records — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of testis with metastases
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

178X

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

1

**21. I certify** that (X) (this hospital) attended the deceased from January 8, 1962 to March 23, 1962 that (X) (we) last saw the deceased alive on March 23, 1962, and that death occured at 10:37 AM the causes and on the date stated above.

**22a. SIGNATURE**: R. T. Brooks Jr. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: March 23, 1962

**22c. PHYSICIAN'S NAME** (Type): R. T. BROOKS LT MC USN

**22d. ADDRESS**: U. S. Naval Hospital, Bethesda, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: Mar. 24, 1962

**23c. NAME OF CEMETERY OR CREMATORY**: Hampton National

**23d. LOCATION** (City, town or county) (State): Hampton, Virginia

**24. FUNERAL DIRECTOR'S SIGNATURE**: W. W. Chambers Co.

**ADDRESS**: W. W. CHAMBERS Funeral Home, 1400 Chapin St., WDC

**25a. REC'D BY REGISTRAR** DATE MAR 27 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03407

## CERTIFICATE OF DEATH

Item 8 Film G308 3/12/62 iwk

03400

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 hrs. 15 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS: Asbury
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Blanche; Middle: E.; Last: Gelman

**4. DATE OF DEATH**: Month: March; Day: 4; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 8/19/1879

**9. AGE** (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Homemaker

**10b. KIND OF BUSINESS OR INDUSTRY**: —

**11. BIRTHPLACE** (County & State, or foreign country): Pennsylvania

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John Lowery

**14. MOTHER'S MAIDEN NAME**: Sarah Rhodes

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no (If yes give were or dates of service): —

**16. SOCIAL SECURITY NO.**: —

**17. INFORMANT**: Francis Porter Address: 369 Ridge Ave, Towson 4, Md.

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
420.0
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that ~~it~~ (this hospital) attended the deceased from MAR. 4, 1962 to MAR. 4, 1962, that ~~it~~ (we) last saw the deceased alive on MAR. 4 1962 and that death occured at 6 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Robert G. Angle M.D.

**22b. DATE SIGNED**: 3-4-62

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22c. PHYSICIAN'S NAME** (Type): Robert G. Angle

**22d. ADDRESS**: 50090 Delray Ave. Bethesda. Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-7-62

**23c. NAME OF CEMETERY OR CREMATORY**: Sandymount Church

**23d. LOCATION** (City, town or county): Sandymount (State): Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: E. L. Partner

ADDRESS: 316 E. Diamond Ave Gaithersburg, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 7 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03408

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03401

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11416 Sherrie Lane

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Silver Spring
d. STREET ADDRESS: 11416 Sherrie Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Marion — Middle: Grason Gibson — Last: Gibson Jr.

**4. DATE OF DEATH**: Month: Mar — Day: 11 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 9-9-25

**9. AGE** (In years last birthday): 36 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Steamfitter

**10b. KIND OF BUSINESS OR INDUSTRY**: John Fitzgerald Co.

**11. BIRTHPLACE** (State or foreign country): Md

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Marion G. Gibson Sr.

**14. MOTHER'S MAIDEN NAME**: Nellie Gass

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWII

**16. SOCIAL SECURITY NO.**: 220-16-4568

**17. INFORMANT**: Barbara Gibson (wife) — Address: Silver Spring

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county):

DATE SIGNED: 3-11-62

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 3-14-62

**22c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill Cemetery

**22d. LOCATION** (City, town, or country) (State): Suitland Prince George's Co. Md.

**23. FUNERAL DIRECTOR**: Raymond A. Ziska — ADDRESS: 8434 Georgia Ave

Warner E. Pumphrey, Inc. Silver Spring, Maryland

**24a. REC'D BY REGISTRAR** DATE: MAR 15 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any data is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

1

03409

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03402

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens San.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X·3
d. STREET ADDRESS: 5524 9th Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Martin Middle: George Last: Gilbertson
4. DATE OF DEATH: Month: Mar Day: 21 Year: 1962

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/22/82
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Mgr. Kennedy-Warren Garage
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Gilbertson
14. MOTHER'S MAIDEN NAME: Augusta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 578-05-5687
17. INFORMANT: Mrs. Lucille Dennison, Address: 5524 9th St. N.W., Wash, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
420.1
DUE TO (b) Hypertensive Arteriosclerotic cardiovasc dis. — 6 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 29, 1958 to Mar 21, 1962, that (I) (we) last saw the deceased alive on Mar. 20 1962, and that death occurred at 5:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: M F Ottman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar 21, 1962
22c. PHYSICIAN'S NAME (Type): M.F. OTTMAN MD
22d. ADDRESS: 11800 Ga Ave RR Md

23a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~
23b. DATE THEREOF: 3/24/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., ADDRESS: 2901 14th St. N.W., Wash, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03410 **CERTIFICATE OF DEATH** 03403

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 43 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 DAMASCUS
d. STREET ADDRESS: 24910 WOODFIELD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First VIOLA Middle L. Last GILLISS
4. **DATE OF DEATH** Month 3 Day 14 Year 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-9-75
9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: GOVT. AGRICULTURAL DEPT.
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN S. GILLISS
14. MOTHER'S MAIDEN NAME: HARRIETT LEANAH RICHKETTS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service)
16. SOCIAL SECURITY NO.: None
17. **INFORMANT** Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli, MASSIVE — INTERVAL BETWEEN ONSET AND DEATH

466X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Pulmonary INFARCT, MULTIPLE

DUE TO (c) Thrombosis DEEP FEMORAL VEINS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 19 62 to March 14, 1962, that (I) (we) last saw the deceased alive on March 14 1962, and that death occured at 3:15P M, from the causes and on the date stated above.

22a. SIGNATURE: G. F. Meadors M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/16/62
22c. PHYSICIAN'S NAME (Type): G. F. MEADORS, M.D.
22d. ADDRESS: DAMASCUS, MARYLAND

23a. BURIAL, CREMATION, REMOVAL: Burial
23b. DATE THEREOF: March 18 1962
23c. NAME OF CEMETERY OR CREMATORY: Rockville Union
23d. LOCATION (City, town or county) (State): Rockville Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis X. Barber
ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VR A15 (4)
15M 7/61

M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03411

## CERTIFICATE OF DEATH

03404

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3911 Military Rd., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X 3

**3. NAME OF DECEASED** (Type or print): First MARY — Middle MARGARET — Last GLESSNER

**4. DATE OF DEATH**: Month March — Day 3, — Year 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Mar.16, 1898

**9. AGE** (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months 11, Days 17 — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Washington, D. C.

**12. CITIZEN OF WHAT COUNTRY?**: U. S.

**13. FATHER'S NAME**: William D. McFarland

**14. MOTHER'S MAIDEN NAME**: Mary Oulihan

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give were or dates of service): 579-28-7272

**17. INFORMANT**: Husband — Address: Reu Glessner — Same as Item #2

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO (b) Metastasis carcinoma to bone & brain — 7 mo.

DUE TO (c) Carcinoma of breast.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1 7 0 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from April 1, 1939, to March 3, 1962, that (I) (we) last saw the deceased alive on March 1, 1962, and that death occured at 11:45 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Gilbert B. Rude M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: March 3, 1962

**22c. PHYSICIAN'S NAME** (Type): GILBERT B. RUDE

**22d. ADDRESS**: 3900 Military rd. N.W DC.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/6/62

**23c. NAME OF CEMETERY OR CREMATORY**: Ft. Lincoln Cemetery

**23d. LOCATION** (City, town or county) (State): Prince George Co. Md.

**24 FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 7 '62

**25b. REGISTRAR'S SIGNATURE**: Vivian L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03412

## CERTIFICATE OF DEATH

03405

**1. PLACE OF DEATH**
a. COUNTY: Montg, MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Gaithersburg. Rural
c. LENGTH OF STAY IN 1b: 40yr
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 08 Gaithersburg. Rural
d. STREET ADDRESS: LongDraft Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Gladys Middle: Josephine Last: Glover

**4. DATE OF DEATH**: Month: Mar Day: 24 Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: Feb 24-1896
**9. AGE** (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: 1 Days: 0
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House Wife
**10b. KIND OF BUSINESS OR INDUSTRY**: Home Work
**11. BIRTHPLACE** (County & State, or foreign country): San Francisco. Calf,
**12. CITIZEN OF WHAT COUNTRY?**: U S A

**13. FATHER'S NAME**: Charles Burdette
**14. MOTHER'S MAIDEN NAME**: Nettie Shuck

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wer or dates of service):
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT**: Mrs Henry Musser, Address: Gaithersburg. Md.

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH: ONE DAY
DUE TO (b) BRAIN ATROPHY — ONE YEAR
DUE TO (c) CARCINOMA OF SPINAL CORD — 5 MONTHS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 193.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
**20c.** TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
**20d.** INJURY OCCURRED: While at work ☐ Not While at work ☐
**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from JUNE 23, 1961 to March 24, 1962, that (I) (we) last saw the deceased alive on MARCH 21 1962 and that death occured at 12:00 PM, from the causes and on the date stated above.

**22a.** SIGNATURE: Gordon S. Rosenberger M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b.** DATE SIGNED
**22c.** PHYSICIAN'S NAME (Type): Gordon S. Rosenberger, M. D.
**22d.** ADDRESS: 310 W. Montgomery Ave, Rockville, Md.

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial
**23b.** DATE THEREOF: 3-27-62
**23c.** NAME OF CEMETERY OR CREMATORY: Park Lawn
**23d.** LOCATION (City, town or county) (State): Rockville. Md.

**24** FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ernest C. Gartner. Gaithersburg. Md.
**25a.** REC'D BY REGISTRAR DATE MAR 27 '62
**25b.** REGISTRAR'S SIGNATURE: Arthur S. Travis

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. This certificate should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any de necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03413 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03406

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1002 Brice Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Rockville
d. STREET ADDRESS: 1002 Brice Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Ellen Last: Golden
4. DATE OF DEATH: Month: Mar Day: 4 Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-15-62
9. AGE (In years last birthday): 0 yrs. IF UNDER 1 YEAR: Months: 0 Days: 19 IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ralph Golden
14. MOTHER'S MAIDEN NAME: Jewel Kurtz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ralph Golden (Father) Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden
475X
DUE TO (b) Upper Respiratory Infection — 24 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-4-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: March 5-1962
22c. NAME OF CEMETERY OR CREMATORY: Lee Crematory
22d. LOCATION (City, town, or country): Washington (State): DC
23. FUNERAL DIRECTOR: Lee Funeral Home ADDRESS: Washington, DC
24a. REC'D BY REGISTRAR DATE: MAR 7 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2147

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03414 **CERTIFICATE OF DEATH** 03407

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1 M 90 I 0 1

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 10 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kensington Gardens Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: FLORIDA
b. COUNTY: Osceola
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MAITLAND, FLORIDA
d. STREET ADDRESS: 123 HOLLIE COURT 48X·3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: VICTOR Middle: E. Last: GOODWIN

**4. DATE OF DEATH**: Month: March Day: 11 Year: 1962

**5. SEX**: MALE

**6. COLOR OR RACE**: White

**7. MARRIED** ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: MAY 11 1879

**9. AGE** (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Electrical Engineer

**10b. KIND OF BUSINESS OR INDUSTRY**: General Electric Corp.

**11. BIRTHPLACE** (County & State, or foreign country): Minneapolis, Minnesota

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Isaac GOODWIN

**14. MOTHER'S MAIDEN NAME**: Ann Craik

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 016-03-5301

**17. INFORMANT**: EDNA GOODWIN Address: 123 Hollie Court

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 10 hours

4 21.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) AORTIC STENOSIS

DUE TO (c) ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PNEUMONIA, LOBAR

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from May, 1961, to March 11, 1962 that (I) (~~we~~) last saw the deceased alive on March 11 1962, and that death occured at 7:35 P.M. from the causes and on the date stated above.

**22a. SIGNATURE** M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ **22b. DATE SIGNED** 3/14/62

**22c. PHYSICIAN'S NAME** (Type): ROBERT F. DYER MD

**22d. ADDRESS**: 915 19th Street, N.W.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): burial

**23b. DATE THEREOF**: 3/14/62

**23c. NAME OF CEMETERY OR CREMATORY**: Rock Creek Cemetery

**23d. LOCATION** (City, town or county) (State): Washington, D.C.

**24 FUNERAL DIRECTOR'S SIGNATURE**: The S.H. Hines Company

ADDRESS: 2901 14th St. N.W. Washington 9, D.C.

**25a. REC'D BY REGISTRAR** DATE: MAR 14 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Thomas

M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03415 **CERTIFICATE OF DEATH** 03408

Items 8 & 9 Film G309 3/15/62 iwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4404 Colfax Street

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Kensington
d. STREET ADDRESS: 4404 Colfax Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Mendez; Middle:; Last: Gottschalk

**4. DATE OF DEATH**: Month: March; Day: 6; Year: 19 62

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: 11/20/83 1882 79/78 yrs.
**9. AGE** (In years last birthday): IF UNDER 1 YEAR: Months 3, Days 16; IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret. Salesman
**10b. KIND OF BUSINESS OR INDUSTRY**: Selling
**11. BIRTHPLACE** (County & State, or foreign country): New York
**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Julius Gottschalk
**14. MOTHER'S MAIDEN NAME**: Marie Rammenstein

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
**16. SOCIAL SECURITY NO.** (If yes give wer or dates of service): 057-16-8244
**17. INFORMANT**: Helen Ellen E. Gottschalk — Address: Helen E. Gottschald, -Wife-same 2d

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DIS — INTERVAL BETWEEN ONSET AND DEATH: years.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from Oct. 9, 1956 to MAR 6, 1962, that (I) (~~we~~) last saw the deceased alive on MAR 5 1962, and that death occured at ....M, from the causes and on the date stated above.

**22a. SIGNATURE** DeWitt E. DeLawter M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED** 3-6-62
**22c. PHYSICIAN'S NAME** (Type): DeWitt E. DeLawter
**22d. ADDRESS**: 3848 Porter Street, N. W., Wash. DC

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3/8/62
**23c. NAME OF CEMETERY OR CREMATORY**: Parklawn Cemetery
**23d. LOCATION** (City, town or county) (State): Rockville, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
**25a. REC'D BY REGISTRAR** DATE MAR 9 '62
**25b. REGISTRAR'S SIGNATURE** Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03416 **CERTIFICATE OF DEATH** 03409

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 26 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 7607 Eastern Avenue

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Takoma Park, Maryland
d. STREET ADDRESS: 1 7607 Eastern Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Phillip; Middle: Henry; Last: Goundie

**4. DATE OF DEATH**: Month: March; Day: 26; Year: 1962

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: June 5, 1882

**9. AGE** (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired Floor Manager

**10b. KIND OF BUSINESS OR INDUSTRY**: Hecht Company

**11. BIRTHPLACE** (County & State, or foreign country): Pennsylvania

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Phillip Goundie

**14. MOTHER'S MAIDEN NAME**: Mary V. Petty

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.**: 578-10-3101

**17. INFORMANT**: Mrs. Iola C.V. Case — Address: Takoma Park, Md. 7607 Eastern Ave.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO (b): Nephrosclerosis — 1 yr.
DUE TO (c): Arteriosclerosis — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Congestive Heart Failure

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

**20d.** INJURY OCCURRED: While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from June, 1960, to 3/25, 1962, that (I) (we) last saw the deceased alive on 3/25, 1962, and that death occured 3:30 AM, from the causes and on the date stated above.

**22a.** SIGNATURE: Sanford J. Randall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b.** DATE SIGNED: 3/26/62
**22c.** PHYSICIAN'S NAME (Type): S. J. RANDALL, M.D.
**22d.** ADDRESS: 3636 16 ST. N.W. D.C.

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial
**23b.** DATE THEREOF: 3-29-62
**23c.** NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
**23d.** LOCATION (City, town or county) (State): Prince George's Co., Maryland

**24** FUNERAL DIRECTOR'S SIGNATURE: Raymond L. Fiske — ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland

**25a.** REC'D BY REGISTRAR — DATE: MAR 30 '62
**25b.** REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03417

## CERTIFICATE OF DEATH

Reg. Dist. No. 03410

M

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6609 Brookville Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Chevy Chase
d. STREET ADDRESS 6609 Brookville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

X

3. NAME OF DECEASED (Type or print) First HARVEY Middle BEECHER Last GRAM
4. DATE OF DEATH Month MAR. Day 26 Year 1962

I

5. SEX MALE
6. COLOR OR RACE CAU.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH NOV 24, 1869
9. AGE (In years last birthday) 92 yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY U.S. War Dept.
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David Gram
14. MOTHER'S MAIDEN NAME Margaret Dell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - -
16. SOCIAL SECURITY NO. - - - - -
INFORMANT Harvey B. Gram, Jr. Address 5804 Overlea Road Washington 16, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic brain syndrome — INTERVAL BETWEEN ONSET AND DEATH: 5 MONS.

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Cerebro-vascular Thrombosis — 6 MONS.

DUE TO (c) Cerebral Arteriosclerosis — UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG 18, 1961, to MAR 26, 1962 that I last saw the deceased alive on MAR 26, 1962, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert S. Poole M.D. ADDRESS (Street, city or town, state) 4501 CONN AVE DATE SIGNED 3/26/62

PHYSICIAN'S NAME (Type) ROBERT S. POOLE, M.D.

1

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-29-1962
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State) Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE Joseph Edwards Jones Inc. ADDRESS 1756 - P St. N.W. Wash. 6, D.C.
24a. REC'D BY REGISTRAR DATE MAR 29 '62
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03418 03411

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kensington Gardens

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 515 Quintana Place N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

47X.3

3. NAME OF DECEASED (Type or print): First: Susie; Middle: E; Last: Duffin

4. DATE OF DEATH: Month: March; Day: 19; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 20, 1879
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Madison, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin F Turner
14. MOTHER'S MAIDEN NAME: Ella Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Dorothy E. Watson — Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b) Congestive Heart Failure — 7 days

DUE TO (c) Hypertensive & Arteriosclerotic Heart Disease — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Feb 28, 1949 to March 19, 1962, that (I) (~~we~~) last saw the deceased alive on March 18 1962, and that death occured at 7:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: Horace H Custis Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/19/62
22c. PHYSICIAN'S NAME (Type): Horace H. Custis, Jr.
22d. ADDRESS: 1852 Columbia Rd., N.W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3/22/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR: DATE MAR 21 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03419 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03412

Item 2 Film G310 4/3/62 lwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Potomac
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Potomac Manor Rest Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg P.G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac Hyattsville 1643
d. STREET ADDRESS: 5451 Newton St. Apt. Potomac Manor Rest Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anne Middle D. Last Grigsby
4. DATE OF DEATH: Month Mar Day 8 Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-21-1874
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alfred Askew
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Rest Home Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: sudden
422.2
DUE TO (b) Chronic Myocarditis — month
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia 2 wks ago
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-8-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 12-62
22c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery
22d. LOCATION (City, town, or country) (State): Richmond Va.

23. FUNERAL DIRECTOR: SIMMONS BROS. ADDRESS: 1661 - GOOD HOPE RD. S.E. WASHINGTON D.C.
24a. REC'D BY REGISTRAR: DATE MAR 12 '62
24b. REGISTRAR'S SIGNATURE: Gertrude S. Krause

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03420 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03413

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3½ hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X·3
d. STREET ADDRESS: 3908 Morrison St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Larry Middle: T. Last: Gurley
4. DATE OF DEATH: Month: March Day: 14 Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: FEB 24, 1896
9. AGE (in years last birthday): 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): I (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 526 07 6928
17. INFORMANT: Charles G. Quinn Address: 118-2nd St. Greenwood Acres Kensington Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Gangrene of intestinal tract — INTERVAL BETWEEN ONSET AND DEATH: 3 days
5702
DUE TO (b) Mesenteric Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 14, 1962
EXAMINER'S NAME (Type): Dr. Frank Broschart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-19-62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR: C.E. Pollock W-W Chambers Co. ADDRESS: 5801 Cleveland Ave Riverdale Md
24a. REC'D BY REGISTRAR DATE: MAR 19 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03421 **CERTIFICATE OF DEATH** 03414

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5½ days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 55 Bethesda
d. STREET ADDRESS: 5073 River Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Lewis; Middle: M.; Last: Hall

**4. DATE OF DEATH**: Month: March; Day: 22; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Colored

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 6/25/29

**9. AGE** (In years last birthday): 32 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Truck driver

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Nathan Hall

**14. MOTHER'S MAIDEN NAME**: Rachael Thompson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no (If yes give were or dates of service)

**16. SOCIAL SECURITY NO.**: 218-20-1697

**17. INFORMANT**: wife — Address: same as above

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subarachnoidal hemorrhage, right
DUE TO (b) Ruptured cerebral aneurysm, middle cerebral artery, right
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 16, 1962 to March 22, 1962 that (I) (we) last saw the deceased alive on Mar. 21 1962, and that death occured at 2:45 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: John L. Lord M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): Dr. John Lord

**22d. ADDRESS**

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/25/62

**23c. NAME OF CEMETERY OR CREMATORY**: Ebnezer Church.,

**23d. LOCATION** (City, town or county) (State): Centerville, Md.

**24. FUNERAL DIRECTOR'S SIGNATURE**: Robert L. Snowden. — ADDRESS: Rockville, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 27 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Thomas

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

99

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03422 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03415

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wash San + Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Silver Spring
d. STREET ADDRESS: 9511 Colesville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Edgar Last: Hallman
4. DATE OF DEATH: Month 3 Day 6 Year 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-8-88
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motion Picture
10b. KIND OF BUSINESS OR INDUSTRY: Projectionist
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Martin Hallman
14. MOTHER'S MAIDEN NAME: Annie Gardner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-05-0631
17. INFORMANT: Mrs. George R. Muschlitz, 104 Franklin Ave., Address Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 3-7-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 9, 1962
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or country) (State): Prince George's County, Md.

23. FUNERAL DIRECTOR: Raymond A. Zisse
ADDRESS: Warner E. Pumphrey, Inc., Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE MAR 9 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03423 **CERTIFICATE OF DEATH** 03416

Item 9 Film G310 4/2/62 mh

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda, Maryland
c. LENGTH OF STAY IN 1b: 30 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Resmor Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria, 83X-3
d. STREET ADDRESS: 11 E. Walnut St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: EDWARD Middle: AUGUSTUS Last: HAMILTON

**4. DATE OF DEATH**: Month: MARCH Day: 24 Year: 1962

**5. SEX**: MALE

**6. COLOR OR RACE**: WHITE

**7. MARRIED** ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Aug. 18, 1885

**9. AGE** (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Insurance Broker

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): New York, N.Y.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: William Hamilton

**14. MOTHER'S MAIDEN NAME**: Poole

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Yes (If yes give war or dates of service): WW I

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: John Hamilton - Son - 144 DS + S.E. Wash 3 DC

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): Congestive heart failure
420.0
DUE TO (b): Arteriosclerotic hypertensive heart disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Renal failure due to Arteriolonephrosclerosis

**19. WAS AUTOPSY PERFORMED?** YES ☑ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~We~~ attended the deceased from March 23, 1962, to March 24, 1962, that (I) (~~We~~) last saw the deceased alive on March 24 1962, and that death occured at 5:12 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Michael M. Dobridge M.D.

ATTENDING PHYS. ☑ ~~MED.~~ DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: March 25, 1962

**22c. PHYSICIAN'S NAME** (Type): Michael Dobridge

**22d. ADDRESS**: 10620 Georgia Ave Silver Springs Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/27/62

**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National

**23d. LOCATION** (City, town or county) (State): Arlington, Va.

**24. FUNERAL DIRECTOR'S SIGNATURE**: James T. Ryan Inc. **ADDRESS**: 317 Penn. Ave. S.E.

**25a. REC'D BY REGISTRAR** DATE MAR 27 '62

**25b. REGISTRAR'S SIGNATURE**: Carlton S. Evans

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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03424

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

03417

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LeDeau Gardens

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Silver Spring
d. STREET ADDRESS: 2100 Hildarose Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia Middle: C. Last: Harding
4. DATE OF DEATH: Month: March Day: 12 Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 9, 1883
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months: 2 Days: Hours: IF UNDER 24 HRS.: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Henry Culver
14. MOTHER'S MAIDEN NAME: Caroline D. Graf
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Address: Kenneth Culver, 7206 Honeywell La., Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebral Vascular Accident | 2 wks |
| DUE TO (b) | Hypertension | 4 yrs |
| DUE TO (c) | Arteriosclerosis | 7 yrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June, 1960, to Mar 12, 1962, that (I) (~~we~~) last saw the deceased alive on Mar 12 1962, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John Lawrence Avery M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-12-62
22c. PHYSICIAN'S NAME (Type): John Lawrence Avery MD.
22d. ADDRESS: 10110 Georgia Ave., Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 15, 1962
23c. NAME OF CEMETERY OR CREMATORY: Colesville Cemetery
23d. LOCATION (City, town, or county) (State): Colesville, Montgomery Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond Q. Zickafoose ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc., Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: MAR 15 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03425 **CERTIFICATE OF DEATH** 03418

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Brookeville
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Brookeville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lillie Middle May Last HARVEY

4. DATE OF DEATH: Month March Day 2 Year 1962

5. SEX: Female
6. COLOR OR RACE: Wh.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 8, 1874
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Frederick Cty. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Carlton Edward OLAND
14. MOTHER'S MAIDEN NAME: Margaret Ann CRAVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none.
17. INFORMANT: C. W. Harvey Address: Brookeville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO (b) Cerebral arteriosclerosis — years
DUE TO (c) Arteriosclerosis — years

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): —

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 1946 to Mar. 2, 1962, that (I) (we) last saw the deceased alive on Mar 2 1962, and that death occured at 11:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard A. Yates MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/2/62
22c. PHYSICIAN'S NAME (Type): Richard A. YATES
22d. ADDRESS: OLNEY, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 5 1962
23c. NAME OF CEMETERY OR CREMATORY: St. Johns
23d. LOCATION (City, town or county): Olney (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE MAR 6 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the hospital record should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Lavtonville, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03426 **CERTIFICATE OF DEATH** 03419

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Hall Nursing Home-Kensington

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: –
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: North Avenue 3401-4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First CLARA Middle Alice Last HAYNIE

**4. DATE OF DEATH** Month March Day 23 Year 1962

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** 1/20/1874

**9. AGE** (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Nurse

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** John Haynie

**14. MOTHER'S MAIDEN NAME:** Elizabeth Berry

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT** Address: Bessie Johnston-2629 Henderson-Silver Spring

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH

4200

DUE TO (b) ESSENTIAL HYPERTENSION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) GENERALIZED ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from JAN. 24, 1957 to March 23, 1962, that (I) (~~we~~) last saw the deceased alive on March 23 1962, and that death occured at 8:10 AM, from the causes and on the date stated above.

**22a. SIGNATURE** Menzie Lowdermilk M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED** March 23 62

**22c. PHYSICIAN'S NAME** (Type)

**22d. ADDRESS** 5206 Norway St. Chevy Chase, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF:** 3/26/62

**23c. NAME OF CEMETERY OR CREMATORY:** Loudon Park Cemetery

**23d. LOCATION** (City, town or county) (State): Baltimore, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** Ellsworth Armacost — ADDRESS: Ellsworth Armacost-4600 Liberty Hghts. Avenue

**25a. REC'D BY REGISTRAR** DATE MAR 27 '62

**25b. REGISTRAR'S SIGNATURE** Arthur S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03427

## CERTIFICATE OF DEATH

03420

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 15 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton, Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Damascus
d. STREET ADDRESS: 25705 Wright Rd.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☑

**3. NAME OF DECEASED** (Type or print): First: Mary — Middle: Welsh — Last: Henderson

**4. DATE OF DEATH**: Month: Mar. — Day: 31 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

**8. DATE OF BIRTH**: May 8 - 1879

**9. AGE** (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: ———

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Warner Welsh

**14. MOTHER'S MAIDEN NAME**: Clara Adams

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: Yes Unknown

**17. INFORMANT** — Address: Mrs. Anne Lindsay-Daughter-same 2d

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO (b): Coronary Stenosis + Insufficiency — 4 years
DUE TO (c): Arteriosclerotic Cardiovascular disease — 10 years

Conditions, if any, which geva rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension. Debility. Senile Brain Syndrome

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) ~~(this hospital)~~ attended the deceased from Sept, 1958 to Mar 31, 1962, that (I) (we) last saw the deceased alive on Mar 31 1962, and that death occured at 1:15 P.M., from the causes and on the date stated above.

**22a. SIGNATURE**: James A. Gannon Jr. M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): JAMES A. GANNON Jr M.D.

**22d. ADDRESS**: 3141-34th St NW

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 4/5/62

**23c. NAME OF CEMETERY OR CREMATORY**: Hyattstown Ch. Cem.

**23d. LOCATION** (City, town or county) (State): Hyattstown, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE APR 6 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Travis

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03428 **CERTIFICATE OF DEATH** 03421

Item 23b, Film G309 3/27/62 iwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Kentucky
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Valley Station 55X·3
d. STREET ADDRESS: 4806 Seville Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Lola Middle: Faye Last: Henning

**4. DATE OF DEATH** Month: March Day: 20, Year: 19 62

**5. SEX:** Female

**6. COLOR OR RACE:** Caucasian

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH:** June 18, 1955

**9. AGE** (In years last birthday): 6 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Child

**10b. KIND OF BUSINESS OR INDUSTRY:** - - - - - - -

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Jack Hardin Henning

**14. MOTHER'S MAIDEN NAME:** Anna Mildred Drane

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service): - - - - - - -

**16. SOCIAL SECURITY NO.:** - - - - - - -

**17. INFORMANT** Address: FATHER: Jack H. Henning, Same as #2

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) hemorrhage, gastrointestinal
DUE TO (b) rhabdomyosarcoma, generalized
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

197.7

INTERVAL BETWEEN ONSET AND DEATH: 48 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that ☒ (this hospital) attended the deceased from March 10, 19 62 to March 20, 19 62 that ☒ (we) last saw the deceased alive on March 20, 19 62 and that death occured at 10:07 from the causes and on the date stated above.

**22a. SIGNATURE** Robert V. Rack M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED** March 20, 1962

**22c. PHYSICIAN'S NAME** (Type): ROBERT V. RACK LT MC USN

**22d. ADDRESS:** U. S. Naval Hospital, Bethesda, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF:** Mar. 24, 1962

**23c. NAME OF CEMETERY OR CREMATORY:** Kingswood Rockville, Md.

**23d. LOCATION** (City, town or county) (State): Kingswood, Kentucky

**24 FUNERAL DIRECTOR'S SIGNATURE** Tyson-Wheeler Tyson-Wheeler Funeral Home, Rockville Pike,

**25a. REC'D BY REGISTRAR** DATE MAR 2 2 '62

**25b. REGISTRAR'S SIGNATURE** Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03429 **CERTIFICATE OF DEATH** 03422

Item 1c Film G310 4/2/62 mh

**1. PLACE OF DEATH**
e. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: ~~15~~ 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4612 South Chelsea Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Pearl; Middle: Ruby; Last: Hertz

**4. DATE OF DEATH**: Month: March; Day: 19; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: February 24, 1910

**9. AGE** (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Social Worker

**10b. KIND OF BUSINESS OR INDUSTRY**: Welfare

**11. BIRTHPLACE** (County & State, or foreign country): Illinois

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Mose Fennell

**14. MOTHER'S MAIDEN NAME**: Minnie Johnson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary infarct — INTERVAL BETWEEN ONSET AND DEATH:
410.0
DUE TO (b): Chronic cor pulmonale — 24 years
DUE TO (c): Scleroderma — 24 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (☒ (this hospital) attended the deceased from March 3, 1962 to March 19, 1962, that (☒ (we) last saw the deceased alive on March 19 1962, and that death occured at 11:00AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Elliot Weser, M.D. M.D.

**22b. DATE SIGNED**: 3/19/62

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

**22c. PHYSICIAN'S NAME** (Type): Elliot Weser, M.D.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Cremation

**23b. DATE THEREOF**: 3/20/62

**23c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill Crematory

**23d. LOCATION** (City, town or county) (State): Suitland, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 22 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03430 **CERTIFICATE OF DEATH** 03423

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): WASHINGTON SAN. + HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: NEW YORK
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BATAVIA 69X·3
d. STREET ADDRESS: 88 MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

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3. NAME OF DECEASED (Type or print): First IVA Middle GRACE Last HESS
4. DATE OF DEATH: Month 3 Day 26 Year 1962
5. SEX: FE
6. COLOR OR RACE: WH
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/29/86
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? Amer
13. FATHER'S NAME: William Hoover
14. MOTHER'S MAIDEN NAME: Elizabeth Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital RECORDS Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHOLEMIC NEPHROSIS AND UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 591X

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): CHOLECYSTOTOMY WITHIN PAST WEEK FOR CHOLELITHIASIS
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-18-62, 19..., to 3-25-62, 19..., that (I) (we) last saw the deceased alive on 3-25-62, 19..., and that death occured 12½ AM, from the causes and on the date stated above.

22a. SIGNATURE: W H Ferguson MD M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): W.H Ferguson MD
22d. ADDRESS: 915 19th St NW DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 28-1962
23c. NAME OF CEMETERY OR CREMATORY: Watts Cemetery
23d. LOCATION (City, town or county) (State): Kearmore Penna.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters
ADDRESS: 254 Farrell St N.E. D.C.
25a. REC'D BY REGISTRAR DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03431

## CERTIFICATE OF DEATH

Reg. Dist. No. 03424

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2502 Arcola Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton 37
d. STREET ADDRESS: 2502 Arcola Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CHARLIE — Middle LOUISE — Last HIGDON

4. DATE OF DEATH: Month March — Day 30 — Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 7, 1906
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Nelson
14. MOTHER'S MAIDEN NAME: Louise Rice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Dorothy Anne Laney, 703 Fletcher Place — Address Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PSEUDO MUCINOUS CARCINOMA OF OVARY — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS
175.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEB 11, 1962 to MAR. 30, 1962 that I last saw the deceased alive on MAR 30, 1962, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Duohy M.D.
ADDRESS (Street, city or town, state): 7720 WISCONSIN AVE BETHESDA, MD.
DATE SIGNED: 3/30/62
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4-4-62
22c. NAME OF CEMETERY OR CREMATORY: HIGHLAND PARK
22d. LOCATION (City, town, or county) (State): MAYFEILD, KY

23. FUNERAL DIRECTOR'S SIGNATURE: Chevy Chase Funeral Home — ADDRESS: 5101 Wisc. Ave N.W.
24a. REC'D BY REGISTRAR DATE: APR 4 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03432 **CERTIFICATE OF DEATH** 03425

Item 18 Film G309 3/22/62 ams

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 52 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residance before admission)
e. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville, 1638.2
d. STREET ADDRESS: 4807 - 70th Place, Woodlawn
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: William (No middle name) Middle: Last: Hite

**4. DATE OF DEATH**: Month: March Day: 16, Year: 19 62

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: 10 September 1923
**9. AGE** (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Central Office Repairman
**10. KIND OF BUSINESS OR INDUSTRY**: Telephone Company
**11. BIRTHPLACE** (County & State, or foreign country): Washington, D.C.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Russell Hite
**14. MOTHER'S MAIDEN NAME**: Ruth Kuhnert

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Yes
(If yes give wars or dates of service): WW II
**16. SOCIAL SECURITY NO.**: 579-20-8884
**17. INFORMANT**: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension — INTERVAL BETWEEN ONSET AND DEATH: 15 hours
204.3
DUE TO (b) Bronchopneumonia and [redacted] — 6 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Acute leukemia — 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from January 23, 1962 to March 16, 1962, that (I) (we) last saw the deceased alive on March 16 1962, and that death occured at 6:10 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Robert H. Levin, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22b. DATE SIGNED**: Mar 16, 1962
**22c. PHYSICIAN'S NAME** (Type): Robert H. Levin M.D.
**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-19-1962
**23c. NAME OF CEMETERY OR CREMATORY**: Arlington Natl
**23d. LOCATION** (City, town or county) (State): Arlington, Va

**24 FUNERAL DIRECTOR'S SIGNATURE**: Robert A Mattingly
ADDRESS: 1317-11 St Wash. D.C.
**25a. REC'D BY REGISTRAR** DATE: MAR 20 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

[redacted]

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03433

## CERTIFICATE OF DEATH

Reg. Dist. No. 03426

M

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 2 1/2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: JOHNSONS NURSING HOME

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COLLEGE PARK 16X2
d. STREET ADDRESS: BERWYN ROAD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

90

**3. NAME OF DECEASED** (Type or print): First: JULIA Middle: Last: HOLLAN

**4. DATE OF DEATH**: Month: MARCH Day: 15 Year: 1962.

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

**8. DATE OF BIRTH**: FEB. 16, 1876

**9. AGE** (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home

**11. BIRTHPLACE** (State or foreign country): HUNGARY

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A

**13. FATHER'S NAME**: Unknown

**14. MOTHER'S MAIDEN NAME**: Unknown

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**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): No (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**: Unknown

**INFORMANT**: Rest Home Records Address:

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

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**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year; Hour a. m. p. m. 19

**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I attended the deceased from June 15 1960, to March 15, 1962 that I last saw the deceased alive on March 15, 1962, and that death occurred at 8:55 PM, from the causes and on the date stated above.

**ACTUAL SIGNATURE** A F Thibadeau M.D. — **ADDRESS** (Street, city or town, state): 10111 COLESVILLE RD — **DATE SIGNED**: 3/15/62.

**PHYSICIAN'S NAME (Type)** A. F. THIBADEAU, M.D. SILVER SPRING MD.

1

**22a. BURIAL, CREMATION, REMOVAL (Specify)**: Burial

**22b. DATE THEREOF**: 3/17/62

**22c. NAME OF CEMETERY OR CREMATORY**: Ft Lincoln

**22d. LOCATION** (City, town, or county) (State): Colmar Manor, Md

**23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: F. Harris Sons Hyattsville, Md

**24a. REC'D BY REGISTRAR** DATE MAR 19 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kruse

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03434 **CERTIFICATE OF DEATH** 03427

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Silver Spring
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): LeDeau

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington - District of Columbia 47X-3
d. STREET ADDRESS: 1900 F. Street, N. W., apt.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SELDEN Middle GRANT Last HOPKINS
4. DATE OF DEATH: Month March Day 30 Year 1962
5. SEX: M
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 5, 1862
9. AGE (In years last birthday): 99 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired - Board of Appeals - Civil Service Commission
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (County & State, or foreign country): Castle Rock, Wis.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jacob Hopkins
14. MOTHER'S MAIDEN NAME: not known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Philip S. Hopkins, son, 3900 16th St., N. W. Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Insanition
DUE TO (b): Aging
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4344

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Heart Disease (Mild Failure Compensated)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Feb 19, 1962 to Mar 30, 1962, that (I) (~~we~~) last saw the deceased alive on Mar 30 1962, and that death occured at 4:50 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Robert J. Thibadeau M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar 30-62
22c. PHYSICIAN'S NAME (Type): ROBERT J. THIBADEAU
22d. ADDRESS: 10609 Concord St. Kensington, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: April 2, 1962
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City, town or county) (State): Fairfax County, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Ives Funeral Home, Inc. J. E. Gray
ADDRESS: 2847 Wilson Blvd., Arlington, Va.
25a. REC'D BY REGISTRAR DATE APR 3 '62
25b. REGISTRAR'S SIGNATURE: Clarence E. Hawes

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Nov 30 '62

Kensington

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03435

## CERTIFICATE OF DEATH

03428

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 days

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 108 Derwood
d. STREET ADDRESS: Redland Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San & Hospital

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Edward — Last: Hottinger

4. DATE OF DEATH: Month: March — Day: 7 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: ~~Ma~~ 8-4-22
9. AGE (In years last birthday): 39 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Field Man-Insp.
10b. KIND OF BUSINESS OR INDUSTRY: Elec.-Pub. Utility
11. BIRTHPLACE (County & State, or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wilbur Hottinger
14. MOTHER'S MAIDEN NAME: Florence Brady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 218-18-5368
17. INFORMANT: Washington Sanitarium + Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain stem compression — INTERVAL BETWEEN ONSET AND DEATH: 4 days
237X
DUE TO (b): Suspected brain tumor — 3 weeks
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): left hemiparesis, cause unknown 6 years

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/26, 1962 to 3/7, 1962 that (I) (we) last saw the deceased alive on 3/7, 1962 and that death occured at 9 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John T. Lord M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/7/62
22c. PHYSICIAN'S NAME (Type): John T. Lord M.D.
22d. ADDRESS: 1015 Spring St. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-10-62
23c. NAME OF CEMETERY OR CREMATORY: Flower Hill
23d. LOCATION (City, town or county) (State): Redland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VR A1S (4)
1SM 7/61

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FOR STATE HEALTH DEPT.

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME-
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03436

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03429

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Silver Spring
d. STREET ADDRESS: 804 Burlington Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Clifton — Last: Housley
4. DATE OF DEATH: Month: 3 — Day: 13 — Year: 1962
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 10, 1910
9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Appliance Store
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Junior Housley
14. MOTHER'S MAIDEN NAME: Estella Hill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 300-07-3457
17. INFORMANT: John Henry Housley — Address: 6609 Poplar St Takoma Park, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: Mar 13-1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-16-62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or country) (State): Prince George's Co, Maryland

23. FUNERAL DIRECTOR: Raymond A. Ziska — ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc., Silver Spring, Maryland

24a. REC'D BY REGISTRAR — DATE: MAR 15 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03437

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03430

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 6105 Wyoming Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 57
d. STREET ADDRESS: 6105 Wyoming Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daisy — Middle: Frances — Last: Huddleson

4. DATE OF DEATH: Month: Mar — Day: 25 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 13 1897
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk - U.S. Treasury
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charlie F. Cornell
14. MOTHER'S MAIDEN NAME: Annie Belle Rutter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 577-60-1390
17. INFORMANT: Harvey Huddleson (husband) — Address: Stu 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-25-62
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/29/62
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Maryland — ADDRESS
24a. REC'D BY REGISTRAR: DATE MAR 27 '62
24b. REGISTRAR'S SIGNATURE: Carlton S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03438

## CERTIFICATE OF DEATH

03431

**1. PLACE OF DEATH**
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Silver Spring
d. STREET ADDRESS: 130 – Woodridge Ave.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Willard Middle: Phillips Last: Hunnewell

**4. DATE OF DEATH**: Month: March Day: 14 Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 1/26/03

**9. AGE** (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Clerical

**10b. KIND OF BUSINESS OR INDUSTRY**: Banking

**11. BIRTHPLACE** (County & State, or foreign country): Lynn Mass.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Wm. Hunnewell

**14. MOTHER'S MAIDEN NAME**: ~~Abby~~ Abbie Phillips.

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give war or dates of service): No 030-03-7777

**17. INFORMANT**: Hazel T. Hunnewell Address: Same As Above

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia + congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks.
DUE TO (b): Acute cor pulmonale — 3 weeks
DUE TO (c): Pulmonary emphysema. — + 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): Carcinoma of bladder + prostate.

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☒

MEDICAL CERTIFICATION

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 11, 1962 to March 14, 1962, that (I) (we) last saw the deceased alive on March 14 1962, and that death occured at 6:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: March 15, 1962

22c. PHYSICIAN'S NAME (Type): BLAINE H. EIG

22d. ADDRESS: 8641 Colesville Rd Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-17-62

23c. NAME OF CEMETERY OR CREMATORY: Forrest Hill Cemetery

23d. LOCATION (City, town or county) (State): Fitchburg, Worcester Co, Mass.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Gisler ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc., Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03439

## CERTIFICATE OF DEATH

03432

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 16 Silver Spring
d. STREET ADDRESS: 1612 Neeley Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: Maxwell — Last: Hunt
4. DATE OF DEATH: Month: March — Day: 30 — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-17-13
9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): auto mechanic
10b. KIND OF BUSINESS OR INDUSTRY: auto - garage
11. BIRTHPLACE (County & State, or foreign country): Newfoundland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Hunt
14. MOTHER'S MAIDEN NAME: Elsie (does not remember)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): WW 2 - army
16. SOCIAL SECURITY NO.:
17. INFORMANT: chart - hospital records. — Address: O. Lindsay.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: One Hour
DUE TO (b): Bronchial Pneumonia — Several Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial Asthma Chronic Emphysema
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 28, 1962 to March 30, 1962 that (I) (we) last saw the deceased alive on March 30, 1962 and that death occured at 10:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Stuart D. Nelson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-30-62
22c. PHYSICIAN'S NAME (Type): STUART D. NELSON
22d. ADDRESS: NASH. SAN + HOSP.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: April 3, 1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l
23d. LOCATION (City, town or county) (State): Arlington VA

24 FUNERAL DIRECTOR'S SIGNATURE: W W Tattersall — ADDRESS: 3603 14th St NW DC 10
25a. REC'D BY REGISTRAR: DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03440 **CERTIFICATE OF DEATH** 03433

1 M 74 1 2 1

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 hrs. 20 mins.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Spencerville, 14
d. STREET ADDRESS: Thompson Road 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Ida — Middle: Mae — Last: Jackson

**4. DATE OF DEATH**: Month: March — Day: 26 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 30/21
9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Private
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clifton George Thomas
14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO.: If yes give war or dates of service: No — 217-32-1344
17. INFORMANT: Milton Jackson Jr. — Address: Same as above.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO (b): Chronic Pulmonary Emphysema. — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/26/62, 19, to 3/26, 1962 that (I) (we) last saw the deceased alive on 3/26 1962, and that death occured at 7:12 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John E. Everett M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/26/62
22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT
22d. ADDRESS: 9400 Conn Ave Kensington

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/30/62
23c. NAME OF CEMETERY OR CREMATORY: Round Oak.,
23d. LOCATION (City, town or county) (State): Spencerville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR: DATE MAR 30 '62
25b. REGISTRAR'S SIGNATURE: Clarence E. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Items 20, 21 Film 309 3-21-62 ms

03441

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03434

1 FOR STATE HEALTH DEPT.

99 M I 2 15 2

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 15740 Goodhope Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Louis Middle: Nathanial Last: Jackson
4. **DATE OF DEATH** Month: March Day: 2, Year: 1962
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 1/23/1900
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Louis B. Jackson
14. MOTHER'S MAIDEN NAME: Laura Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service):
16. SOCIAL SECURITY NO.:
17. **INFORMANT**: Hester H. Hackley, Address: item 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exposure to cold
932.0
DUE TO (b) Acute alcoholism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Found dead in an unheated tool shed at home.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-2-62
EXAMINER'S NAME (Type): Frank J. Broschart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/4/62
22c. NAME OF CEMETERY OR CREMATORY: Sandy Spring,
22d. LOCATION (City, town, or country) (State): Sandy Spring, Md.

23. FUNERAL DIRECTOR: Robert L. Snowden ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: MAR 7 '62
24b. REGISTRAR'S SIGNATURE: Cathryn S. Kraus

VS. AISME SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03442

## CERTIFICATE OF DEATH

03435
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 6 1/2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 3719 Kanson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Chester Middle: Clayton Last: James

4. DATE OF DEATH: Month: March Day: 23 Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 23, 1922
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles E. James
14. MOTHER'S MAIDEN NAME: Essa E. Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W W II
16. SOCIAL SECURITY NO.: 577-22-8374
17. INFORMANT: Mrs. Charles E. James — Same Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 29, 1961, to March 23 1962, that I last saw the deceased alive on March 23, 1962, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip E. Jones M.D. ADDRESS (Street, city or town, state): 918 ~~Silver Spring~~ Ellsworth Drive DATE SIGNED: 3/23/62
PHYSICIAN'S NAME (Type): Phillip E. Jones Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar 26-62
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros. Funeral Home ADDRESS: 1661 - Good Hope Rd SE Wash DC
24a. REC'D BY REGISTRAR DATE: MAR 27 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Marra

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be returned to hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03443 **CERTIFICATE OF DEATH** 03436

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4949 Battery Lane

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 46 Bethesda
d. STREET ADDRESS: 4949 Battery Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGE Middle: WALDEMAR Last: JENSEN
4. DATE OF DEATH: Month: MARCH Day: 20 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 6, 1886
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping - Steam Ship - Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Copenhagen, Denmark
12. CITIZEN OF WHAT COUNTRY? U.S. Naturalized.
13. FATHER'S NAME: Waldemar Jensen
14. MOTHER'S MAIDEN NAME: Hansine Jensen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give year or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife Johanna Jensen Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL FAILURE WITH INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 HRS.
DUE TO (b): GENERALIZED ARTERIOSCLEROSIS & ARTERIOSCLEROTIC — 2 yrs.
DUE TO (c): HEART DISEASE QUADRIPLEGIC PAST 4 MONTHS, RESULT CVA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CVA WITH CORD INJURY - FOUR MONTHS AGO
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 1950 to MAR 20, 1962 that (I) (we) last saw the deceased alive on MAR 20 1962, and that death occured at 12:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: William B. Walsh M.D. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar 20 1962
22c. PHYSICIAN'S NAME (Type): WILLIAM B. WALSH M.D.
22d. ADDRESS: 1835 EYE ST. N.W. - WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3/23/62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d. LOCATION (City, town or county) (State): Prince George Co., Md.

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03444

## CERTIFICATE OF DEATH

03437

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Marilea Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 Silver Spring
d. STREET ADDRESS: 10,400 Hayes Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: H.; Last: Johnson
4. DATE OF DEATH: Month: March; Day: 6; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 10, 1875
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Egg salesman
10b. KIND OF BUSINESS OR INDUSTRY: Own business
11. BIRTHPLACE (County & State, or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 579-28-1657
17. INFORMANT: Mrs. Elmer W. Michels Address: 10,400 Hayes Ave, S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 7 1 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December, 1961, to March 6, 1962, that (I) (we) last saw the deceased alive on March 5 1962, and that death occured at 11:55 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 7, 1962
22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr., M.D.
22d. ADDRESS: 9301 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-9-62
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zeller ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03445

## CERTIFICATE OF DEATH

03438

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash San + Hosp

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: Essex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tappahannock 83X-3
d. STREET ADDRESS: Box 56
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: EVA — Middle: ~~Lorraine~~ Lorren — Last: Johnston

**4. DATE OF DEATH**: Month: 3 — Day: 6 — Year: 1962

**5. SEX**: ~~M~~ female

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

**8. DATE OF BIRTH**: 9-23-79

**9. AGE** (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own home

**11. BIRTHPLACE** (County & State, or foreign country): West VA

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: FRANKLIN BECK

**14. MOTHER'S MAIDEN NAME**: Elizabeth STUMP

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: MR. O M. JONES — Address: 806 HERON Dr S Md

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

DUE TO (b): Senile Arteriosclerosis — 10 yrs.

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 11 Feb 1962 to 6 Mar 1962 that (I) (~~we~~) last saw the deceased alive on 5 Mar 1962, and that death occured at 8:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: S B Queen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7 Mar 1962

22c. PHYSICIAN'S NAME (Type): S. B. QUEEN

22d. ADDRESS: 7112 Willow Ave TAKOMA PARK Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-9-62

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION (City, town or county) (State): Fredericksburg Spottsylvania Co ~~Tappahannock Essex Co.~~ Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zisk — ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland

25a. REC'D BY REGISTRAR: DATE MAR 9 '62

25b. REGISTRAR'S SIGNATURE: Anthony L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03446 03439

1 M 74 I 0 1

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SUBURAN HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 BETHESDA (WESTHAVEN)
d. STREET ADDRESS: 5103 BROOKVILLE DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Mollie Middle: C. Last: JUMP

**4. DATE OF DEATH**: Month: MAR Day: 12 Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 19 JUNE 1864
9. AGE (In years last birthday): 97 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERICAL
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVR
11. BIRTHPLACE (County & State, or foreign country): BALTIMORE, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: SAMUEL ADAMS FLICKNER
14. MOTHER'S MAIDEN NAME: JANE REED
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MR K. FOOTE Address: ABOVE

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 12 MAR 62
52 24
DUE TO (b): GENERAL DETERIORATION
Conditions, if any, which geve rise to immediate cause (e), steting the underlying cause lest.
DUE TO (c): HYPOSTATIC PNEUMONIA ~~FRACTURE LT HIP~~ — 14 FEB 62

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): FRACTURE LT HIP
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): PT FELL AT HOME
20c. TIME OF INJURY Hour a.m. p.m. 12 NOON Month, Day, Year FEB 14 62 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME
20f. (City or town): WEST HAVEN (County): MONT. (State): Md

21. **I certify** that (I) (this hospital) attended the deceased from 15 FEB., 1962 to 12 MAR., 1962, that (I) ~~(we)~~ last saw the deceased alive on 9 MAR 1962 and that death occured at 3 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Marvin M Gibson M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12 Mar 62
22c. PHYSICIAN'S NAME (Type): MARVIN M GIBSON
22d. ADDRESS: 1835 EYE ST NW WASH D C

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 3/14/62
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 14 '62
25b. REGISTRAR'S SIGNATURE: Clinton S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Coronor notified and approved

VR A15 (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03447 **CERTIFICATE OF DEATH** 03440

Item 9 Film G309 3/27/63

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83X-3
d. STREET ADDRESS: 941 N. VanDoren
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Lucille Middle: Marie Last: Juskie

**4. DATE OF DEATH**: Month: March Day: 20, Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: May 24, 1926

**9. AGE** (In years last birthday): 35 yrs. 36 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Lake Charles, La.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: H. L. PEARCE

**14. MOTHER'S MAIDEN NAME**: Laura Barrett

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give war or dates of service): - - - - - - -

**16. SOCIAL SECURITY NO.**: 437 24 5927

**17. INFORMANT** Address: HUSBAND: Ben Juskie, Same as #2

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Carcinoma of Breast

DUE TO (b) Brain Metastasis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c)

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that ☒ (this hospital) attended the deceased from March 6, 1962, to March 20, 1962, that ☒ (we) last saw the deceased alive on March 20, 1962, and that death occured 1:00PM from the causes and on the date stated above.

**22a. SIGNATURE** William C. Monell M.D.

**22b. DATE SIGNED** March 20, 1962

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22c. PHYSICIAN'S NAME** (Type): WILLIAM C. MONELL LT MC USN

**22d. ADDRESS**: U. S. Naval Hospital, Bethesda, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-23-62

**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National

**23d. LOCATION** (City, town or county) (State): Arlington, Virginia

**24 FUNERAL DIRECTOR'S SIGNATURE** M. P. Quirk — **ADDRESS**: Everly-Wheatley Funeral Home, Alexandria, Va.

**25a. REC'D BY REGISTRAR** — DATE MAR 23 '62

**25b. REGISTRAR'S SIGNATURE** Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03448 **CERTIFICATE OF DEATH** 03441

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington, 42
d. STREET ADDRESS: 10604 Wheatley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Herbert; Middle: (No middle name); Last: Kahler

**4. DATE OF DEATH**: Month: March; Day: 29; Year: 19 62

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 20 December 1896

**9. AGE** (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Bio. Physicist & P.H.D.

**10b. KIND OF BUSINESS OR INDUSTRY**: Federal Government

**11. BIRTHPLACE** (County & State, or foreign country): Oregon

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Orange Kahler

**14. MOTHER'S MAIDEN NAME**: Lena Dunlap

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 9 years
DUE TO (b) Septicemia — 6 hours
DUE TO (c) Possible viral hepatitis — 2 weeks

204.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 092X

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20e. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 26, 1962 to March 29, 1962, that (I) (we) last saw the deceased alive on March 29, 1962, and that death occured at 10:20 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Martin J. Cline M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: 3/29/62

**22c. PHYSICIAN'S NAME** (Type): Martin J. Cline, MD.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/31/62

**23c. NAME OF CEMETERY OR CREMATORY**: Rockville Cemetery

**23d. LOCATION** (City, town or county) (State): Rockville, Maryland

**24. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE APR 2 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03449 **CERTIFICATE OF DEATH** 03442

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 58 Cabin John
d. STREET ADDRESS: 6516-76th. Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle E. Last Kane
4. DATE OF DEATH: Month March Day 9 Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/16/94
9. AGE (In years on last birthday): 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: U
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Kane
14. MOTHER'S MAIDEN NAME: Annie Behrens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 578-20-5261
17. INFORMANT: Albert Kearney
Address: 414-35th St. N.W. Wash., D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute generalized peritonitis
DUE TO (b): Ulcer, duodenum
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/24, 1962 to 3/9, 1962, that (I) (we) last saw the deceased alive on 3/9 1962, and that death occured at 5 pm, from the causes and on the date stated above.

22a. SIGNATURE: W. Joyce M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/62
22c. PHYSICIAN'S NAME (Type): W. F. JOYCE
22d. ADDRESS: 8106 MAPLE RIDGE RD. BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-12-62
23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collinsby
ADDRESS: 3821 14th St. N.W. Wash., D.C.
25a. RECD BY REGISTRAR DATE: MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed by the attending physician within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03450

## CERTIFICATE OF DEATH

Reg. Dist. No. 03443

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C. ~~MARYLAND~~
b. COUNTY: ~~MONTGOMERY~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D.C. 47X3
d. STREET ADDRESS: 1416 Holly St NW, WASH.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BLANCHE Middle S. Last KAUFFMAN
4. DATE OF DEATH: Month 3 Day 16 Year 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-23-89
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John H. Summerville
14. MOTHER'S MAIDEN NAME: Margaret ~~Hineman~~ McCaskey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Harvey E. Kauffman Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

420.0

DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — 7 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-10, 1962, to 3-16, 1962, that I last saw the deceased alive on 3-16, 1962, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard H. Pollen M.D. ADDRESS (Street, city or town, state): 10511 Summitt Avenue DATE SIGNED: 3-16-62

PHYSICIAN'S NAME (Type): Richard Henry Pollen, M.D. Kensington, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-20-62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond Gisler ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE MAR 20 '62
24b. REGISTRAR'S SIGNATURE: Gordon L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

15

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03451 03444

M 74

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x3
d. STREET ADDRESS: 3735 Jocelyn ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: Spriggs; Last: Kelley

4. DATE OF DEATH: Month: March; Day: 25; Year: 1962

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-22-81

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Kelley IV

14. MOTHER'S MAIDEN NAME: Felicia Elizabeth Spriggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

(If yes give war or dates of service): - -

16. SOCIAL SECURITY NO.: - - -

17. INFORMANT: Address: Mrs. Enid Anthony - Sister

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO (b) Cancer Prostate c Metastises — 4 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Yeer 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1958, 19..., to 3-25, 1962 that (I) (we) last saw the deceased alive on 3-25 1962, and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Curtis S. Blumenthal M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: 5315 CONN. AVE. WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 3-26-1962

23c. NAME OF CEMETERY OR CREMATORY: Rehoboth Cemetery

23d. LOCATION (City, town or county) (State): Rehoboth, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Jos. Gawler's Sons, Inc. ADDRESS: 1756 Pa. Ave NW Washington 6, DC

25a. REC'D BY REGISTRAR DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Fiana

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed [illegible] 24 hours after death. [illegible] 4 [illegible] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03452

## CERTIFICATE OF DEATH

03445

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San. + Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 15
d. STREET ADDRESS: 621 Hollywood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Harold — Middle: Leon — Last: Kelly

**4. DATE OF DEATH**: Month: March — Day: 26 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 1/11/93

**9. AGE** (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired Fed. Employee

**10b. KIND OF BUSINESS OR INDUSTRY**: U.S. Government

**11. BIRTHPLACE** (County & State, or foreign country): Michigan

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Charles W. Kelly

**14. MOTHER'S MAIDEN NAME**: Julia Lee

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.**: 217-34-1593

**17. INFORMANT**: Wash. San. + Hosp. — Address: Carroll Ave., Takoma Park, Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis, generalized {PRIMARY IN TAIL OF PANCREAS — INTERVAL BETWEEN ONSET AND DEATH: 6 months +
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

15 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Lobar pneumonia, with hydrothorax

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1950, to Mar. 26, 1962, that (I) (we) last saw the deceased alive on Mar 26 1962, and that death occured at 9:30 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: John N. Andrews M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3-27-62
**22c. PHYSICIAN'S NAME** (Type): John N. Andrews
**22d. ADDRESS**: 9601 Colesville Rd Silver Spring Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-29-62
**23c. NAME OF CEMETERY OR CREMATORY**: George Washington Cemetery
**23d. LOCATION** (City, town or county) (State): Hyattsville Pr. George's Maryland

**24. FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Zeller — ADDRESS: 434 Georgia Ave
(or) Warner E. Pumphrey, Inc. Silver Spring, Md.
**25a. REC'D BY REGISTRAR** DATE: MAR 29 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. A copy should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03453

## CERTIFICATE OF DEATH

03446

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: - - -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 4509 Butterworth Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X·3

74

**3. NAME OF DECEASED** (Type or print): First: Mary — Middle: F. — Last: Kelly

**4. DATE OF DEATH**: Month: 3 — Day: 10 — Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐
**8. DATE OF BIRTH**: 5/13/83
**9. AGE** (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE
**10b. KIND OF BUSINESS OR INDUSTRY**: - - -
**11. BIRTHPLACE** (County & State, or foreign country): WASHINGTON D.C.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: ANDREW MILLS
**14. MOTHER'S MAIDEN NAME**: ELIZABETH AHERN.

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service): No
**16. SOCIAL SECURITY NO.**:
**17. INFORMANT**: MARGT KELLY — Address: 4509 Butterworth Pl. N.W. D.C.

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**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary infarct, rt. lower lobe — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Thrombosis, pulmonary artery, rt. lower
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 65X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease

**19. WAS AUTOPSY PERFORMED?** YES ☑ NO ☐

2

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 3/1, 1962 to 3/10, 1962, that (I) (~~we~~) last saw the deceased alive on 3/10 1962 and that death occured at 9 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Marvin Wadler M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**
**22c. PHYSICIAN'S NAME** (Type): Dr. Marvin Wadler
**22d. ADDRESS**: 8816 Maywd. Ave., Silver Spring

1

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-14-1962
**23c. NAME OF CEMETERY OR CREMATORY**: Mt. Olivet Cemetery
**23d. LOCATION** (City, town or county) (State): Washington, D. C.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Joe. Gawler Sons, Inc.
ADDRESS: 1756 Pa. Ave. N.W. WASH., D.C.
**25a. REC'D BY REGISTRAR** DATE MAR 13 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur J. Thomas

**TO HOSPITAL PHYSICIAN:** The law requires that the death certificate be executed [illegible] 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03454 **CERTIFICATE OF DEATH** 03447

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 20 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kensington Gardens Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Silver Spring, ~~Maryland~~
d. STREET ADDRESS: 1515 E. Falkland Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Edith; Middle: W.; Last: Kidwell

**4. DATE OF DEATH**: Month: March; Day: 10; Year: 1962

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 27, 1882
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Grenville Whitaker
14. MOTHER'S MAIDEN NAME: Laura S. Clark
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 577-05-2097 P
17. INFORMANT: Robert W. Kidwell — Address: 314 Northwest Dr. Silver Spring Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b) Arteriosclerotic Heart Disease — ?
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4-20-0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 1950 to March 10, 1962 that (I) (we) last saw the deceased alive on March 10 1962, and that death occured at 10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: J. Marion Bankhead M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/62
22c. PHYSICIAN'S NAME (Type): J. Marion Bankhead
22d. ADDRESS: 9241 Col. Blvd Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 13 3-14-62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fiske ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 13 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03455 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03448

**1. PLACE OF DEATH**
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Clarksburg (rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Johnson Rd

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Clarksburg
d. STREET ADDRESS: Johnson Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Ernest Middle: W. Last: King

**4. DATE OF DEATH** Month: Mar. Day: 1 Year: 1962

**5. SEX:** male

**6. COLOR OR RACE:** white

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH:** 10-28-82

**9. AGE** (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Farmer

**10b. KIND OF BUSINESS OR INDUSTRY:** Own farm

**11. BIRTHPLACE** (State or foreign country): Md

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** John B King

**14. MOTHER'S MAIDEN NAME:** Lilly Burns

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.:** Yes

**17. INFORMANT:** Lee King — Address: Cedar Grove, Md

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b) hypertension — yrs
DUE TO (c)

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

**ACTUAL SIGNATURE** Frank J. Broschart M.D.

**EXAMINER'S NAME** (Type) FRANK J. BROSCHART

Address (Street, city, town, or county):

**DATE SIGNED** 3-1-62

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF:** 3/3/62

**22c. NAME OF CEMETERY OR CREMATORY:** Bethesda Methodist

**22d. LOCATION** (City, town, or country) (State): Brownsville, Md.

**23. FUNERAL DIRECTOR:** Olin L. Molesworth — ADDRESS: Damascus, Md.

**24a. REC'D BY REGISTRAR** DATE MAR 5 '62

**24b. REGISTRAR'S SIGNATURE** Arthur S. Kraus

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03456 **CERTIFICATE OF DEATH** 03449

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wash San & Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Silver Spring
d. STREET ADDRESS: 10400 Colesville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Elinor Middle: Matilda ~~Matilda~~ Last: Kinsman

**4. DATE OF DEATH**: Month: March Day: 16 Year: 1962

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-23-~~72~~ 72
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: Oliver Kinsman
14. MOTHER'S MAIDEN NAME: Emma Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hosp. Record — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO (b): Generalized arteriosclerosis — many years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonitis; acute renal failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from January, 1962 to March 16, 1962 that (I) (we) last saw the deceased alive on March 15 1962, and that death occured at 5:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Bennet A. Porter Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 16, '62
22c. PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr., M.D.
22d. ADDRESS: 9301 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-19-62
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville Montgomery Co, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zieber ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc., Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03457 **CERTIFICATE OF DEATH** 03450

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenwood 13X·2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle CATHERINE Last KRAMER

4. DATE OF DEATH: Month 3-7 Day Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-2-1890
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Basil H. Grimes
14. MOTHER'S MAIDEN NAME: Ida Tasker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mr. Fred Kramer (Husband) Address: Glenwood, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis, acute — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO (b) Diabetes, hypertension, cerebral — 60 to
DUE TO (c) failure, cardiac arrest - — 1962

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 19..., to 7 March 1962 that (I) (we) last saw the deceased alive on 7 March 1962, 19..., and that death occured at 5:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Howard E. Hall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7 March 62
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: Aspenville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-10-62
23c. NAME OF CEMETERY OR CREMATORY: Providence
23d. LOCATION (City, town or county) (State): Glenelg, Md

24 FUNERAL DIRECTOR'S SIGNATURE: F.C. Higinbothom, Ellicott City, Md
ADDRESS:
25a. REC'D BY REGISTRAR DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03458 **CERTIFICATE OF DEATH** 03451

Item 23b, Film G308 3/12/62 iwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, NNMC

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Chevy Chase
d. STREET ADDRESS: 5053 Bradley Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Michael — Middle: Benjamin — Last: Krom

**4. DATE OF DEATH**: Month: March — Day: 1 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Cauc

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 19 November 1960

**9. AGE** (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): - - - -

**10b. KIND OF BUSINESS OR INDUSTRY**: - - - -

**11. BIRTHPLACE** (County & State, or foreign country): North Carolina

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Byron Earnest Krom

**14. MOTHER'S MAIDEN NAME**: Adlyn Lee

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT** — Address: Father: Byron Earnest Krom, same as #2

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hand-Schuller Christian Dis. — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

289.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that ~~I~~ (this hospital) attended the deceased from 17 February, 1962, to 1 March, 1962, that ~~I~~ (we) last saw the deceased alive on 1 March 19 62, and that death occured at 4:10 PM from the causes and on the date stated above.

**22a. SIGNATURE** M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: 2 March 1962

**22c. PHYSICIAN'S NAME** (Type): H.A. Pearson, LCDR MC USN

**22d. ADDRESS**: U.S. Naval Hospital

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: March 5, 1962

**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National

**23d. LOCATION** (City, town or county) (State): Arlington, Virginia

**24. FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: Bethesda, Md.

Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.

**25a. REC'D BY REGISTRAR** DATE: MAR 5 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03459

## CERTIFICATE OF DEATH

03452

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Maryander Rest Home

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47x-3
d. STREET ADDRESS: 532-20th St. N.W.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Zera — Middle: A. — Last: Kullman

**4. DATE OF DEATH**: Month: March — Day: 6 — Year: 1962.

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Aug. 3, 1871

**9. AGE** (In years last birthday): 90 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Wash. D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: ? Beach

**14. MOTHER'S MAIDEN NAME**: Mary M. Posey

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: Esther Kullman — Address: 2 D.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | Interval between onset and death |
|---|---|---|
| 422 | IMMEDIATE CAUSE (a) Gangrene, rt. leg. | 2 days |
| | DUE TO (b) Embolus, rt. femoral artery | 2 days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | DUE TO (c) Arteriosclerotic cardiovascular disease | 10 days |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

MEDICAL CERTIFICATION

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from June 9, 1956 to March 6, 1962 that (I) (~~this~~) last saw the deceased alive on March 5, 1962 and that death occured at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE: James D. Kerr M.D. — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/6/61

22c. PHYSICIAN'S NAME (Type): James D. Kerr M.D.
22d. ADDRESS: Damascus, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/9/62
23c. NAME OF CEMETERY OR CREMATORY: Congressional Cem
23d. LOCATION (City, town or county) (State): Wash. D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon
ADDRESS: 4748 Wisc. Ave. N.W.
25a. REC'D BY REGISTRAR DATE: MAR 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03460

## CERTIFICATE OF DEATH

03453

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San + Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1020 University Blvd.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George; Middle: Lyman; Last: Lamb

4. DATE OF DEATH: Month: March; Day: 4; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-23-78
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Government ?
10b. KIND OF BUSINESS OR INDUSTRY: Retired Fed Gov't
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lyman H. Lamb
14. MOTHER'S MAIDEN NAME: Martha Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Patients Chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour
DUE TO (b): arteriosclerotic heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): carcinoma of bladder

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-11-29-61 19 to 12-14-61 19 that (I) (we) last saw the deceased alive on 12-14 1961, and that death occured at 9:50 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Arthur J. Wilets M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Arthur J. Wilets
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-7-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Suitland Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: Wash. D.C.
25a. REC'D BY REGISTRAR: DATE MAR 9 '62
25b. REGISTRAR'S SIGNATURE: William S. Mann

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03461 03454

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Silver Spring
d. STREET ADDRESS: 12,502 Denley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Lilian ~~[illegible]~~ Middle: Mary Last: LAMB

**4. DATE OF DEATH**: Month: 26 March Day: Year: 1962

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: June 14, 1869

**9. AGE** (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Sect and clerk Ret.

**10b. KIND OF BUSINESS OR INDUSTRY**: U.S.Navy Department

**11. BIRTHPLACE** (County & State, or foreign country): Washington, D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: (unknown) Lamb

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: Mrs. Louise Darling Address: Silver Spring, Md. 12,502 Denley Rd.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b) ASCVD — yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility, Thrombophlebitis

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

**20d.** INJURY OCCURRED: While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Jan 30, 1962 to 26 Mar, 1962, that (I) (~~this~~) last saw the deceased alive on 22 Mar 1962 and that death occured at 11:25 P.M. from the causes and on the date stated above.

**22a.** SIGNATURE: Horace W. Bernton, M.D.
**22b.** DATE SIGNED: 3/26/62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22c.** PHYSICIAN'S NAME (Type): Horace W. Bernton
**22d.** ADDRESS: 4743 Bradley Blvd., Ch Ch 15, Md

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial
**23b.** DATE THEREOF: 3-28-62
**23c.** NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
**23d.** LOCATION (City, town or county) (State): Prince George's County, Md.

**24** FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
**25a.** REC'D BY REGISTRAR DATE: MAR 30 '62
**25b.** REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL PHYSICIAN:** The law requires that the death certificate be executed [illegible] 24 hours after death. Page [illegible] retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03462

## CERTIFICATE OF DEATH

03455

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be exec[illegible] in 24 hours after death. [illegible] be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 11912 Rockinghorse Road

2. USUAL RESIDENCE (Where deceased lived, if institution, last place before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Rockville
d. STREET ADDRESS: 11912 Rockinghorse Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle L. Last LAWSON

4. DATE OF DEATH: Month MARCH Day 25 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/8/1900
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard B. Pace
14. MOTHER'S MAIDEN NAME: Mildred E. Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Roy J. Lawson-Husband Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

151X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/ 1961, to 3/25/ 1962 that (I) (we) last saw the deceased alive on 3/23/ 1962, and that death occured at 10:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Donald Nelson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/25/62
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: 10620 Georgia Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/29/62
23c. NAME OF CEMETERY OR CREMATORY: Washington National
23d. LOCATION (City, town or county) (State): Suitland Md

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home
ADDRESS: 300 4th NE D.C.
25a. REC'D BY REGISTRAR DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03463 Reg. Dist. No. 03456

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN 1b 7wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rockville
d. STREET ADDRESS Luckett Ave. P.O. Box 501
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Lucy Middle Anne Last Lewis
4. DATE OF DEATH Month March Day 28 Year 1962
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-13-1879
9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Culpepper-
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjamin Franklin Myers
14. MOTHER'S MAIDEN NAME Evelyn Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Evelyn K. Gore Address 11601 Nairn Rd. Silver Spring Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident

DUE TO (b) Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-4-, 1962, to 3-28-, 1962, that I last saw the deceased alive on 2-25-, 1962, and that death occurred at 10 39 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Joseph E. Smith, Jr. M.D. ADDRESS (Street, city or town, state) Burtonsville, Md. DATE SIGNED 3/28/62

PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr. Burtonsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF March 31, 1962
22c. NAME OF CEMETERY OR CREMATORY Hopewell Church Cem.
22d. LOCATION (City, town, or county) Lignum (State) Virginia

23. FUNERAL DIRECTOR'S SIGNATURE Per A. Blair ADDRESS East Montg. Ave. Rockville, Maryland
Tyson Wheeler Funeral Home
24a. REC'D BY REGISTRAR DATE APR 2 '62
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03464

## CERTIFICATE OF DEATH

03457

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 51 I 2 1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83X·3
d. STREET ADDRESS: 3206 Wellington Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul Middle: William Last: LINDNER

4. DATE OF DEATH: Month: March Day: 27 Year: 1962

5. SEX: Male

6. COLOR OR RACE: Caucasion

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-10-78

9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Elmont, L.I., N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Lindner

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 094 30 1168

17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myelomonoblastic Leukemia — INTERVAL BETWEEN ONSET AND DEATH

204.3

DUE TO (b) Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While of work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-23-62, 19, to 3-27-62, 19, that (I) (we) last saw the deceased alive on 27 March 19.62, and that death occured at 640PM, from the causes and on the date stated above.

22a. SIGNATURE: W F Warrender M.D.

22b. DATE SIGNED: March 28, 1962

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): W. F. WARRENDER LT MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Smithtown

23d. LOCATION (City, town or county) (State): Smithtown L.I., NY.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Md.
Robert A. Pumphrey Funeral Home, 7557 Wisc., Ave

25a. REC'D BY REGISTRAR DATE: MAR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

VR A1S (4)
1SM 7/61

Have requested Lake Lawn
Funeral Home

13

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03465 **CERTIFICATE OF DEATH** 03458

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 600 McNeill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Paul; Middle: ; Last: Lindsey

**4. DATE OF DEATH**: Month: March; Day: 5; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 9-12-1896

**9. AGE** (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): RETIRED

**10b. KIND OF BUSINESS OR INDUSTRY**: COMMERCE COM. USGOV

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: James E. Lindsey

**14. MOTHER'S MAIDEN NAME**: Mary J. Kirk

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown):
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Belle H. Lindsey — Address: 600 McNeill Rd, Sil Sp., Md

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary thrombosis
4 20.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1954, 19, to March 5, 1962, that (I) (we) last saw the deceased alive on March 1 1962, and that death occured at 9:15 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: Bennet A. Porter, Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: March 5, 1962

**22c. PHYSICIAN'S NAME** (Type): Bennet A. Porter, Jr, M.D.

**22d. ADDRESS**: 9301 Colesville Rd., Silver Spring, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-7-62

**23c. NAME OF CEMETERY OR CREMATORY**: Presbyterian Cemetery

**23d. LOCATION** (City, town or county) (State): Alexandria Virginia

**24 FUNERAL DIRECTOR'S SIGNATURE**: Deal Funeral Home — ADDRESS: 4812 Ga Ave N.W., Wash. DC

**25a. REC'D BY REGISTRAR** DATE MAR 9 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Mann

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03466 **CERTIFICATE OF DEATH** 03459

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 12 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 869 Northampton
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella Middle: May Last: Lodge
4. DATE OF DEATH: Month: Mar Day: 29 Year: 1962
5. SEX: Fem
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 20 1877
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John T Conner
14. MOTHER'S MAIDEN NAME: Mary Eliz. Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs M ~~Lodge~~ Kurland, 869 Northampton, Silver Spring Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 5/25/62
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cor. Fibrillation — 6 Mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/17/ 1962 to 3/29/ 1962 that (I) (we) last saw the deceased alive on 3/27/ 1962 and that death occurred at 7 A M, from the causes and on the date stated above.

22a. SIGNATURE: Howard T. Moore M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/29/62
22c. PHYSICIAN'S NAME (Type): Howard T. Moore
22d. ADDRESS: 7030 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 31, 1962
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Prince Geo. County, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters
ADDRESS: 254 Carroll St NW. Wash. DC
25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03467

## CERTIFICATE OF DEATH

03460

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**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. (Page 4) be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kensington Gardens San.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 6300 Tilden Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Reginald — Middle: B. — Last: Looker

**4. DATE OF DEATH**: Month: 3 — Day: 6 — Year: 1962

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 2-21-73

**9. AGE** (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Bank Teller

**10b. KIND OF BUSINESS OR INDUSTRY**: Banking

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Thomas H. Looker

**14. MOTHER'S MAIDEN NAME**: L. Brigham

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Yes — (If yes give war or dates of service): Spanish Amer

**16. SOCIAL SECURITY NO.**: 577-22-1999

**17. INFORMANT**: Reginald B. Looker, Jr.-Son-same 2d — Address:

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 6 days.
DUE TO (b) Diffuse bilateral pulmonary fibrosis. — ?
DUE TO (c) cause undetermined.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT, WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Mar. 5 to Mar. 6, 1962 that (I) (~~we~~) last saw the deceased alive on Mar. 4, 1962 and that death occured at 12 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: George A. Gray Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3/6/62

**22c. PHYSICIAN'S NAME** (Type): George A. Gray Jr. MD

**22d. ADDRESS**: 4740 Chevy Chase Dr. Ch. Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/8/62

**23c. NAME OF CEMETERY OR CREMATORY**: Arlington Nat. Cem

**23d. LOCATION** (City, town or county) (State): Arlington, Virginia

**24. FUNERAL DIRECTOR'S SIGNATURE**: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 9 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03468 **CERTIFICATE OF DEATH** 03461

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Silver Spring
d. STREET ADDRESS: 2425 Ross Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Gordon — Middle: Truett — Last: Lovett

**4. DATE OF DEATH**: Month: March — Day: 5 — Year: 19 62

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: June 29, 1926
**9. AGE** (In years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Printer
**10b. KIND OF BUSINESS OR INDUSTRY**: Printing
**11. BIRTHPLACE** (County & State, or foreign country): Texas
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Charles Lovett
**14. MOTHER'S MAIDEN NAME**: Ida Martin

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service)
**16. SOCIAL SECURITY NO.**: 451-32-1501
**17. INFORMANT**: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b) Hypertension — 5 years
DUE TO (c) Diabetes Mellitus — 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 1, 1962, to March 5, 19 62, that (I) (we) last saw the deceased alive on March 5, 19 62, and that death occured at 5:50 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: Samuel Barondes M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22b. DATE SIGNED**: March 8, 1962
**22c. PHYSICIAN'S NAME** (Type): Samuel Barondes, M.D.
**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3/9/62
**23c. NAME OF CEMETERY OR CREMATORY**: Memo. Gardens
**23d. LOCATION** (City, town or county) (State): Amarillo, Texas

**24 FUNERAL DIRECTOR'S SIGNATURE**: W.W. Chambers Co.
ADDRESS: 8655 Ga. ave. Silver Spring Md
**25a. REC'D BY REGISTRAR** DATE: MAR 12 '62
**25b. REGISTRAR'S SIGNATURE**: Clifford E. Evans

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03469

## CERTIFICATE OF DEATH

03462

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 17 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLNAD
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GAITHERSBURG
d. STREET ADDRESS: Rt. 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

**3. NAME OF DECEASED** (Type or print): First: SETH — Middle: HASKELL — Last: LOW

**4. DATE OF DEATH**: Month: 3 — Day: ~~20~~ 30 — Year: 62 — 19

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5-20-11
9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED-Biologist
10b. KIND OF BUSINESS OR INDUSTRY: Wild Life
11. BIRTHPLACE (County & State, or foreign country): MASS.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: RUSSELL C. LOW
14. MOTHER'S MAIDEN NAME: ALICE KEITH PRESCOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-36-3983
17. INFORMANT: HOSPITAL RECORDS — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolus
DUE TO (b): Astrocytoma of Rt Cerebrum
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

193.0

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/13 1962, to 3/30 1962, that (I) (we) last saw the deceased alive on 3/29 1962, and that death occurred at 5:05A M, from the causes and on the date stated above.

22a. SIGNATURE: C. H. Ligon M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 3/30/62
22c. PHYSICIAN'S NAME (Type): CHARLES H. LIGON, M.D.
22d. ADDRESS: SANDY SPRING, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3-31-62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City, town or county) (State): Prince George Co. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR — DATE: APR 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Drake

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03470

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03463

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville (rural)
c. LENGTH OF STAY IN 1b: 5yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dover Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mnty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09 Rockville
d. STREET ADDRESS: Dover Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: — Last: Luckett
4. DATE OF DEATH: Month: Mar — Day: 24 — Year: 1962
5. SEX: male
6. COLOR OR RACE: col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-2-1905
9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John P. Luckett
14. MOTHER'S MAIDEN NAME: Amanda Nelson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give year or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Arzella L. Clark (sister) Rockville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE: Cerebral hemorrhage + laceration (left cerebral lobe) — INTERVAL BETWEEN ONSET AND DEATH: Sudden

983X

DUE TO (b): Fracture of skull

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Struck by a blunt instrument

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Repeatedly struck with a hammer at home
20c. TIME OF INJURY: Hour a.m. 3:55 — Month, Day, Year: 3-24 1962
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Rockville (County): Mnty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-24-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/28/62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National.,
22d. LOCATION (City, town, or country): Arlington, Va. (State):

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Robert L. Snowden, Rockville, Md.
24a. REC'D BY REGISTRAR: DATE MAR 29 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03471

## CERTIFICATE OF DEATH

03464

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83X-3
d. STREET ADDRESS: 2411 N. Upshur Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: JANE Middle: E. Last: McDONALD

**4. DATE OF DEATH**: Month: MARCH Day: 12 Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 12-26-1878

**9. AGE** (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: - - -

**11. BIRTHPLACE** (County & State, or foreign country): England

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Thomas Martin Thompson

**14. MOTHER'S MAIDEN NAME**: Emma Brown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give wer or dates of service): - - -

**16. SOCIAL SECURITY NO.**: - - -

**17. INFORMANT**: Leone Robinson Address: 2411 N. Upshur St. Arlington, Va.

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
DUE TO (b) ESSENTIAL HYPERTENSION
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

444X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from AUG. 8, 1961, to MARCH 12, 1962, that (I) (~~we~~) last saw the deceased alive on MARCH 12 1962 and that death occured at 1:15 PM, from the causes and on the date stated above.

**22a. SIGNATURE**: Henry Lowder M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/12/62

**22c. PHYSICIAN'S NAME** (Type):

**22d. ADDRESS**: 5206 NORWAY DR, CHEVY CHASE, Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Removal

**23b. DATE THEREOF**: 3-13-1962

**23c. NAME OF CEMETERY OR CREMATORY**: Beech Woods Cemetery

**23d. LOCATION** (City, town or county) (State): Beech Woods, Pa.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Joseph Gawler's Sons

ADDRESS: 1756 Pa. Ave. N.W. Wash. D.C.

**25a. REC'D BY REGISTRAR** DATE: MAR 14 '62

**25b. REGISTRAR'S SIGNATURE**: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03472 **CERTIFICATE OF DEATH** 03465

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. **PLACE OF DEATH** a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CLARKSBURG
d. STREET ADDRESS: RT. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ELLIOTT Middle GRANVILLE Last MACE
4. **DATE OF DEATH** Month 3 Day 28 Year 19 62
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-18-01
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARETAKER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: XXXXXX WILLIAM A. MACE
14. MOTHER'S MAIDEN NAME: ANNA MCCLOUD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 232-03099
17. INFORMANT: HOSPITAL RECORDS Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 5 days.
DUE TO (b) Arteriosclerosis — years.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/23, 1962, to 3/28, 1962 that (I) (~~we~~) last saw the deceased alive on 3/28 1962 and that death occured at 3:32 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard A. Yates M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 3/29/62
22c. PHYSICIAN'S NAME (Type): RICHARD A. YATES, M.D.
22d. ADDRESS: OLNEY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/30/62
23c. NAME OF CEMETERY OR CREMATORY: Methodist
23d. LOCATION (City, town or county) (State): Clarksburg Md.
24 FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton, ADDRESS: Barnesville, Md.
25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: Anthony S. Krama

VR A15 (4)
15M 7/61

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FOR STATE HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03473 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03466

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1hr. 40min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia 47X·3
d. STREET ADDRESS: 6106 1st Place N.E
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Edmund Middle: S. Last: Majchrzyk

**4. DATE OF DEATH**: Month: March Day: 25 Year: 1962

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: December 27, 1924

**9. AGE** (In years last birthday): 37 yrs. IF UNDER 1 YEAR: Months: 2 Days: 26 IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Electrician

**10b. KIND OF BUSINESS OR INDUSTRY**: Construction

**11. BIRTHPLACE** (State or foreign country): New York City

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Stanley Majchrzyk

**14. MOTHER'S MAIDEN NAME**: Stella Kobra

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Yes (If yes give wars or dates of service): W.W. II

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Nonnie Majchrzyk Address: 6106 1st Place N.E

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE THORACIC AND ABDOMINAL HEMORRAGE — INTERVAL BETWEEN ONSET AND DEATH: 2 HOURS

816 X

DUE TO (b) CRUSHED CHEST AND RUPTURED SPLEEN — 〃

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) AUTO ACCIDENT — 〃

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): FRACTURE LEFT HIP AND LEFT LOWER LEG

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. EXTERNAL CAUSE WAS** PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of Item 18.): Driver of car involved in head on collision

**20c. TIME OF INJURY** Hour a.m. p.m.: 12:05 p.m. Month, Day, Year: 3-25 1962

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☒

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): Street

**20f.** (City or town): Chillum (County): P.G. (State): Md

**21. I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

DATE SIGNED: 3-25-62

**22a. BURIAL, CREMATION, REMOVAL** (Specify): CREMATION

**22b. DATE THEREOF**: 3/26/1962

**22c. NAME OF CEMETERY OR CREMATORY**: FORT LINCOLN CREMATORY

**22d. LOCATION** (City, town, or country) (State): PRINCE GEORGES COUNTY, MARYLAND

**23. FUNERAL DIRECTOR**: Jerry E. Hysong ADDRESS: HYSONG'S FUNERAL HOME 1300 N. ST, N.W. - WASH. D.C.

**24a. REC'D BY REGISTRAR** DATE: MAR 28 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03474

## CERTIFICATE OF DEATH

03467

**1. PLACE OF DEATH**
a. COUNTY: Montg, MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 1 Yr.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg,
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1210 Crawford Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Exie; Middle: Salena; Last: Mann

**4. DATE OF DEATH**: Month: Mar; Day: 16th; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb 24-1879
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months: 0 Days: 22 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Lovettsville. Va,
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles K. Muff
14. MOTHER'S MAIDEN NAME: Etta S. Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs Lucille Graham. Rockville. Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO (b) arteriosclerotic cardiovascular disease — 5 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 11, 1962 to March 16, 1962 that (I) (we) last saw the deceased alive on March 14, 1962 and that death occured at 10:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm A. Linthicum M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/16/62
22c. PHYSICIAN'S NAME (Type): Wm A. Linthicum
22d. ADDRESS: 110 S. Washington St, Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-19-62
23c. NAME OF CEMETERY OR CREMATORY: Lovettsville Union
23d. LOCATION (City, town or county) (State): Lovettsville. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. ADDRESS: Gaithersburg. Md.
25a. REC'D BY REGISTRAR DATE MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03475 **CERTIFICATE OF DEATH** 03468

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Illinois
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pekin
d. STREET ADDRESS: 1405 South Capitol Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

51X-3

3. NAME OF DECEASED (Type or print): First Richard, Middle Allen, Last Manwarren
4. DATE OF DEATH: Month March, Day 3, Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 24, 1932
9. AGE (In years last birthday): 29 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman
10b. KIND OF BUSINESS OR INDUSTRY: Caterpillar tractors
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Glenn A. Manwarren
14. MOTHER'S MAIDEN NAME: Mabel L. Irwin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): Korean War
16. SOCIAL SECURITY NO.: Unavailable
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Chronic myelogenous leukemia — 14 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from March 1, 1962 to March 3, 1962 that ☒ (we) last saw the deceased alive on March 3, 1962, and that death occured at 6:15 AM from the causes and on the date stated above.

22a. SIGNATURE: Thorne S. Winter, III M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3-3-62
22c. PHYSICIAN'S NAME (Type): Thorne S. Winter, III
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 3/5/62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town or county) (State): Canton, Illinois

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 7 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03476 03469

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 12hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital
MARYLAND

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8604 Mayfair Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Nina Middle: Mary Last: Marinari

**4. DATE OF DEATH** Month: 3 Day: 22 Year: 1962

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH:** 8-8-99

**9. AGE** (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (County & State, or foreign country): Italy

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Vincent Juliano

**14. MOTHER'S MAIDEN NAME:** Rose (Unknown)

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT:** Pt's chart
Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive encephalopathy
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

**20d.** INJURY OCCURRED While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3-22 1962, to 3-22, 1962, that (I) (we) last saw the deceased alive on 3-22 1962 and that death occured at 8:48 A.M., from the causes and on the date stated above.

**22a.** SIGNATURE: J. Merendino M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b.** DATE SIGNED

**22c.** PHYSICIAN'S NAME (Type): John J. Merendino, M.D.

**22d.** ADDRESS: Silver Spring Md

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial

**23b.** DATE THEREOF: 3-26-62

**23c.** NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

**23d.** LOCATION (City, town or county) (State): Washington, D.C.

**24** FUNERAL DIRECTOR'S SIGNATURE: F. J. Hoolins
ADDRESS: Wash. D.C. 3821-14th St. N.W.

**25a.** REC'D BY REGISTRAR DATE: MAR 27 '62

**25b.** REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03477 **CERTIFICATE OF DEATH** 03470

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harpers Ferry 85 x 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Mayme Middle: M. Last: Marquette

**4. DATE OF DEATH** Month: March Day: 22 Year: 1962

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH:** 9/6/78

**9. AGE** (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired, Post Mistress

**10b. KIND OF BUSINESS OR INDUSTRY:** U.S. Govt.

**11. BIRTHPLACE** (County & State, or foreign country): Virginia

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Thomas J. Burleigh

**14. MOTHER'S MAIDEN NAME:** Marthe Moore

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no (If yes give war or dates of service): no

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT:** Cornelia M. Jones Address: Ch. Ch., Md. 6921 Strathmore St.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma, Lungs and Liver
DUE TO (b): Primary undetermined
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Sept 19 59, to March 22 1962 that (I) (we) last saw the deceased alive on March 22 1962 and that death occured at 1:15 p.m. from the causes and on the date stated above.

**22a. SIGNATURE** Michael M. Healy M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED** 3/22/62
**22c. PHYSICIAN'S NAME** (Type) Michel M. HEALY,
**22d. ADDRESS** WASHINGTON CLINIC WASH, 15, DC

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF:** 3/27/62
**23c. NAME OF CEMETERY OR CREMATORY:** St. Peters
**23d. LOCATION** (City, town or county) (State): Bolivar, W. Va.

**24 FUNERAL DIRECTOR'S SIGNATURE** Tyson Wheeler ADDRESS 1331 Edmonston Ave Rockville, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 27 '62
**25b. REGISTRAR'S SIGNATURE** Clifton S. Hines

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03478

## CERTIFICATE OF DEATH

03471

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 745 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Avenel, 67X-3
d. STREET ADDRESS: 7 Manor Place
a. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Gertrude; Middle: Josephine; Last: Marsh

4. DATE OF DEATH: Month: March; Day: 15; Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 2 April 1893
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Store
11. BIRTHPLACE (County & State, or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Marsh
14. MOTHER'S MAIDEN NAME: Madeline Mistler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Not available
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CIRCULATING anticoagulant & massive left retroperitoneal hemorrhage, peritonial, pleural — INTERVAL BETWEEN ONSET AND DEATH: 2½ years
DUE TO (b) atelectasis left lung — 4 days
DUE TO (c) necrosis left kidney 2° pressure from hematoma — 2 days — 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 29, 1960 to March 15, 1962, that (I) (we) last saw the deceased alive on March 15 1962, and that death occurred 4:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Louis M. Aledort, M.D.
22b. DATE SIGNED: March 16, 1962
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. PHYSICIAN'S NAME (Type): Louis M. Aledort M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit 3-16-62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: St.Gertrude's Cemetery
23d. LOCATION (City, town or county) (State): Colonia, New Jersey

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR: DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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FOR STATE HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03479

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03472

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Silver Spring
d. STREET ADDRESS 4516 Randolph Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Robert Last: Martin

4. DATE OF DEATH Month: 3 Day: 2 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 17, 1938

9. AGE (In years last birthday): 23 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumbers helper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Edward Martin

14. MOTHER'S MAIDEN NAME: Winifred Mae Redwine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): Navy 1955-1956

16. SOCIAL SECURITY NO.:

17. INFORMANT: Winifred Mae Crawford Address: Mother

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
DUE TO (b) Bilateral Bronchio-pneumonia, acute
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

491X

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Bauschart M.D.

EXAMINER'S NAME (Type) FRANK J. Bauschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED Mar 3 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6 MAR 1962

22c. NAME OF CEMETERY OR CREMATORY: Arlington

22d. LOCATION (City, town, or country): Arl (State) Va.

23. FUNERAL DIRECTOR: Francis Funeral Home ADDRESS: 7400 Georgia Ave. Wash. DC

REC'D BY REGISTRAR DATE MAR 7 '62

24b. REGISTRAR'S SIGNATURE: Curtiss S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03480 **CERTIFICATE OF DEATH** 03473

Item 5 Film G309 3/23/62 jwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Silver Spring
d. STREET ADDRESS: 13106 Holdridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

74

**3. NAME OF DECEASED** (Type or print): First EDGAR Middle J. Last MATTINGLY

**4. DATE OF DEATH**: Month March Day 16, Year 1962

5. SEX: Male / Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 13, 1882
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months 1, Days 3 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Railroad
10b. KIND OF BUSINESS OR INDUSTRY: Railroading
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? USA

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13. FATHER'S NAME: David Mattingly
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give were or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema. — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Heart failure

522X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 3/16/62, 19....., to 3/16/62, 19....., that (I) (~~we~~) last saw the deceased alive on 3/16/62 19....., and that death occured at 1:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: A W Smith M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar. 16, 1962
22c. PHYSICIAN'S NAME (Type): ASHBY W. SMITH
22d. ADDRESS: 13018 Georgia Ave., Wheaton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 3-17-62
23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
23d. LOCATION (City, town or county) (State): Reno, Nevada

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03481 **CERTIFICATE OF DEATH** 03474

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4700 Locust Hill Circle

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 44 Bethesda
d. STREET ADDRESS: 4700 Locust Hill Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First INEZ Middle Last MAYHEW
4. DATE OF DEATH: Month March Day 23, Year 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 11, 1874
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months 5 Days 12 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Barnesville, Ohio
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: James Price
14. MOTHER'S MAIDEN NAME: Mary Connor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Daughter Mrs. Helen M. Lee Address: Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Congestive Heart Failure | 1 week |
| DUE TO (b) | Arteriosclerotic Heart Disease | 7 YEARS |
| DUE TO (c) | Generalized Arteriosclerosis | 10 Years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchiectasis, chronic
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this~~ hospital) attended the deceased from DEC. 30, 1954, to MAR. 23, 1962 that (I) (we) last saw the deceased alive on March 17 1962, and that death occurred at 12:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert G. Angle, M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/23/62
22c. PHYSICIAN'S NAME (Type): ROBERT A. ANGLE
22d. ADDRESS: 5009 Del Ray Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 3-23-62
23c. NAME OF CEMETERY OR CREMATORY: Dorset Cemetery
23d. LOCATION (City, town, or county) (State): Dorset, Ohio
24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Clifton S. Frame

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03482 **CERTIFICATE OF DEATH** 03475

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Kentucky
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frankfort, 55X·3
d. STREET ADDRESS: Route # 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Kenneth — Middle: Allen — Last: McDaniel

**4. DATE OF DEATH**: Month: March — Day: 27, — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 9 May 1934

**9. AGE** (In years last birthday): 27 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Plumber Helper

**10b. KIND OF BUSINESS OR INDUSTRY**: Plumbing

**11. BIRTHPLACE** (County & State, or foreign country): Kentucky

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Nathan McDaniel

**14. MOTHER'S MAIDEN NAME**: Eliza Cotton

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 404-38-8449

**17. INFORMANT**: The Medical Record, — Address: The Clinical Center, Bethesda 14, Maryland

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Embolus, pulmonary artery — INTERVAL BETWEEN ONSET AND DEATH: Terminal
754.7
DUE TO (b) Congestive heart failure — months
DUE TO (c) Congenital heart disease, Corrected transposition of Great vessels with mitral insufficiency — 27 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

MEDICAL CERTIFICATION

**21. I certify** that (I) (this hospital) attended the deceased from Feb. 27, 1962 to March 27, 1962, that (I) (we) last saw the deceased alive on March 27 1962, and that death occured at 3 pM, from the causes and on the date stated above.

**22a. SIGNATURE**: James R. Carter Jr. M.D.

**22b. DATE SIGNED**: 3/28/62

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22c. PHYSICIAN'S NAME** (Type): James R. Carter, Jr., M.D.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial-transit

**23b. DATE THEREOF**: 3-28-62

**23c. NAME OF CEMETERY OR CREMATORY**: Sunset Memorial Gardens

**23d. LOCATION** (City, town or county) (State): Woodford County, Ky.

**24 FUNERAL DIRECTOR'S SIGNATURE**: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 30 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03483

## CERTIFICATE OF DEATH

03476

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 hr. 35 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8009 - Piney Branch Rd.
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willard; Middle: L.; Last: McDaniel
4. DATE OF DEATH: Month: March; Day: 2; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/31/01
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Automobiles
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Wesley McDaniel
14. MOTHER'S MAIDEN NAME: Clara Queen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 275-46-4345
17. INFORMANT: Bernice McDaniel — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Posterior myocardial infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 3 HOURS
DUE TO (b) ASHD
DUE TO (c) Peripheral vascular collapse

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar. 2, 1962 to Mar. 2, 1962 that (I) (we) last saw the deceased alive on Mar. 2 1962 and that death occured at 8:50 PM from the causes and on the date stated above.

22a. SIGNATURE: Philip R. Farmer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3-6-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Suitland Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 - Geo. ave N.W.
25a. REC'D BY REGISTRAR — DATE: MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Gilbert S. Krause

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03484 Item 14 Film G310 4/9/62 1wk

## CERTIFICATE OF DEATH

03477

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 705 Alvin Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2212.2

**3. NAME OF DECEASED** (Type or print): First: Keith — Middle: Brian — Last: Mc Grath

**4. DATE OF DEATH**: Month: MARCH — Day: 30, — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: June 8,1961

**9. AGE** (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: 9 Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Child

**10b. KIND OF BUSINESS OR INDUSTRY**: ----------

**11. BIRTHPLACE** (County & State, or foreign country): Montana

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Kenneth Mazick Mc Grath

**14. MOTHER'S MAIDEN NAME**: Myrna Campbell

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service): ----------

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Hospital Records — Address:

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 3312 HEMORRHAGE, CEREBRAL
331X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 28, 1962, to March 30, 1962, that (I) (we) last saw the deceased alive on March 30 19.62, and that death occured at 4:32PM from the causes and on the date stated above.

**22a. SIGNATURE**: Lewis P. Scott M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): Lewis P. Scott LCDR MC USN

**22d. ADDRESS**: U. S. Naval Hospital , Bethesda,Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 4-1-62

**23c. NAME OF CEMETERY OR CREMATORY**: Parsons

**23d. LOCATION** (City, town or county) (State): Salisbury,Maryland

**24. FUNERAL DIRECTOR'S SIGNATURE**: Norman T. Baker/ng
ADDRESS: Hill & Johnson Co. 705 E.Main St. Salisbury,Md.

**25a. REC'D BY REGISTRAR** DATE APR 3 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be exe[illegible] within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1163

M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03485

## CERTIFICATE OF DEATH

03478

**1. PLACE OF DEATH**
a. COUNTY: Montgomery ~~Kensington Gardens Sanatorium~~ MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanatorium

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: NORFOLK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PORTSMOUTH 83X-3
d. STREET ADDRESS: 1810 PRENTIS AVE ~~3000 McComas Ave Kens. Md~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Delia Middle: F. Last: McHorney

**4. DATE OF DEATH**: Month: 3 Day: 18 Year: 1962

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Dec 18 1870

**9. AGE** (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own home

**11. BIRTHPLACE** (County & State, or foreign country): ~~U.S.A.~~ Virginia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Benjamin Lukefundie II

**14. MOTHER'S MAIDEN NAME**: Frances Coleman

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes give were or dates of service): None

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: George McHorney 9119 Bradford Rd, S.S., Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 day
DUE TO (b): Congestive heart failure — 2 mos.
DUE TO (c): Arteriosclerotic Heart Disease — 5 yrs

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

**20d.** INJURY OCCURRED: While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 11, 1961, to 3/18/, 1962, that (I) (we) last saw the deceased alive on 3/18 1962, and that death occured at 11:25 PM, from the causes and on the date stated above.

**22a.** SIGNATURE: Donald Nelson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b.** DATE SIGNED: 3/18/62

**22c.** PHYSICIAN'S NAME (Type): ~~Donad~~ Donald Nelson

**22d.** ADDRESS: 11,128 Norlee Drive, Silver Spring, Md.

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial
**23b.** DATE THEREOF: 3-21-62
**23c.** NAME OF CEMETERY OR CREMATORY: Olive Branch Cemetery
**23d.** LOCATION (City, town or county) (State): Portsmouth Norfolk Virginia

**24** FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fiske ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland

**25a.** REC'D BY REGISTRAR DATE: MAR 21 '62
**25b.** REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1 FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03486

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03479

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 20 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Chauncey Funeral Home

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Silver Spring
d. STREET ADDRESS: 3505 Olympic St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Andrew — Middle: Paul — Last: McKay

**4. DATE OF DEATH**: Month: Mar — Day: 30 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Nov 15 1895

**9. AGE** (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Supt. - Storage Co. - retired

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): ~~Md~~ D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.C.

**13. FATHER'S NAME**: ~~Wm~~ William McKay.

**14. MOTHER'S MAIDEN NAME**: Elizabeth Lang

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Edith M. Stewart — Address: 710 Fifth Ave Silver Spring

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of Item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 3-30-62

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**22b. DATE THEREOF**: April 3-1962
**22c. NAME OF CEMETERY OR CREMATORY**: Gate of Heaven
**22d. LOCATION** (City, town, or country) (State): Georgia Ave Montg Co - Md.

**23. FUNERAL DIRECTOR**: Arthur Walters — ADDRESS: 254 Farragut St NW

**24a. REC'D BY REGISTRAR** DATE: APR 3 '62
**24b. REGISTRAR'S SIGNATURE**: Arthur W. Mears

1
FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03480

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookmont
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Army Map Service 1600 Wealthy Blvd

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Va
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 1313 N Hudson St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

83 x 3

3. NAME OF DECEASED (Type or print): First John, Middle Bernard, Last McKnee
4. DATE OF DEATH: Month Mar, Day 14, Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-28-1907
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lithe. pressman
10b. KIND OF BUSINESS OR INDUSTRY: Army map ser.
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harry H. McKnee
14. MOTHER'S MAIDEN NAME: Jessie Robertson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Army map Service records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration
DUE TO (b) bullet wound thru skull
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: sudden

97 6X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound thru skull — 38 cal.
20c. TIME OF INJURY: Hour 10:20 a.m. Month, Day, Year 3-14 1962
20d. INJURY OCCURRED: While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Army Map Ser
20f. (City or town) Brookmont (County) Mont'y (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-14-62

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: March 17, 1962
22c. NAME OF CEMETERY OR CREMATORY: Glenwood
22d. LOCATION (City, town, or country) (State): Washington, D.C.

23. FUNERAL DIRECTOR: Ives Funeral Home, Inc. — ADDRESS: Arlington, Virginia
J. C. Gray.
24a. REC'D BY REGISTRAR DATE MAR 15 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Thrane

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03488 **CERTIFICATE OF DEATH** 03481

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA 14.
d. STREET ADDRESS: 4503 HIGHLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

50 / 1

**3. NAME OF DECEASED** (Type or print): First LESLIE Middle D. Last MEASELL

**4. DATE OF DEATH**: Month MARCH Day 28 Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/6/21
9. AGE (in years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Leslie D. Measell SR.
14. MOTHER'S MAIDEN NAME: Fannie Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): Army
16. SOCIAL SECURITY NO.: 577-28-9347
17. INFORMANT: Wife Jean K. Measell Same as above — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma liver - metastatic — 7
DUE TO (b) CARCINOMA, FLOOR of Mouth — 2y
DUE TO (c)

143X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct., 1955, to Mar. 28, 1962, that (I) (we) last saw the deceased alive on 3-28, 1962, and that death occured at 7.35 AM, from the causes and on the date stated above.

22a. SIGNATURE: Alfred S. Norton M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/28/62
22c. PHYSICIAN'S NAME (Type): Alfred S. Norton
22d. ADDRESS: Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/2/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

1

FOR STATE HEALTH DEPT.

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2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 [illegible] after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03489

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03482

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 15
d. STREET ADDRESS: 10111 Brock Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: (NMN) — Last: Menick
4. DATE OF DEATH: Month: 3 — Day: 7 — Year: 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-?-89
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Tievel Kendal
14. MOTHER'S MAIDEN NAME: Dina Rosenberg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mrs Sylvia Resnick — Address: 10119 Brock Dr. S.S. Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | ACUTE RIGHT CORONARY OCCLUSION | SUDDEN |
| DUE TO (b) | PULMONARY HEMORRHAGE, MASSIVE | SUDDEN |
| DUE TO (c) | BRONCHOPNEUMONIA, ACUTE | DAYS, FEW, |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 91X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-8-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/9/62
22c. NAME OF CEMETERY OR CREMATORY: D.C. Lodge Cem.
22d. LOCATION (City, town, or country) (State): Wash., D.C.
23. FUNERAL DIRECTOR: Leedley Funeral Home — ADDRESS: 4217-9th Ave
24a. REC'D BY REGISTRAR DATE: MAR 12 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

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# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03490

## CERTIFICATE OF DEATH

03483

1. PLACE OF DEATH
a. COUNTY: Montgomery Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Bethesda
d. STREET ADDRESS: 14 North Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Pawson Last: Mider
4. DATE OF DEATH: Month: Mar. Day: 27, Year: 19 62
5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 8, 1871
9. AGE (In years last birthday): 90 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.A.
13. FATHER'S NAME: George Pawson
14. MOTHER'S MAIDEN NAME: ~~Mary~~ Mary Bradley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Son Kenneth Mider Address: RD #1 Hornell, New York

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS — UNDETERMINED
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

3 2 2X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/26/61, 19__, to 3/27, 1962, that (I) (we) last saw the deceased alive on 3/27, 1962, and that death occurred at 3:45 AM from the causes and on the date stated above.

22a. SIGNATURE: John H. Tuohy M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar. 27, 1962
22c. PHYSICIAN'S NAME (Type): JOHN N. TUOHY
22d. ADDRESS: 7720 Wisconsin Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/30/62
23c. NAME OF CEMETERY OR CREMATORY: Arkport Cemetery
23d. LOCATION (City, town, or county) (State): Steuben County, N. Y.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03491

## CERTIFICATE OF DEATH

03484

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jacksonville
d. STREET ADDRESS: Howerton Apts. Apt. #7
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

70X·3

3. NAME OF DECEASED (Type or print): First: Dale — Middle: Robert — Last: Milks
4. DATE OF DEATH: Month: March — Day: 20, — Year: 19 62
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 28, 1962
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months 1, Days 20; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Richard Milks
14. MOTHER'S MAIDEN NAME: Nancy Lawrence
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Meningomyelocele
DUE TO (b) Hydrocephalus
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7512

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from March 7, 1962, to March 20, 19 62 that (☒ (we) last saw the deceased alive on March 20, 19 62 and that death occured at 8:05 PM from the causes and on the date stated above.

22a. SIGNATURE: Frederic Schulaner M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 21, 1962
22c. PHYSICIAN'S NAME (Type): Frederic A. Schulaner LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/23/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson W. Wheeler
ADDRESS: Tyson-Wheeler Funeral Home, Rockville Pike, Rockville, Md.
25a. REC'D BY REGISTRAR DATE MAR 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A1S (4)
1SM 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03492 **CERTIFICATE OF DEATH** 03485

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1360 Peabody Street, N.W. Apt 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47x·3

**3. NAME OF DECEASED** (Type or print): First: Edna — Middle: Lorena — Last: Miller

**4. DATE OF DEATH**: Month: March — Day: 11 — Year: 19 62

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: October 6, 1890

**9. AGE** (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): None

**10b. KIND OF BUSINESS OR INDUSTRY**: None

**11. BIRTHPLACE** (County & State, or foreign country): Illinois

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Levi G. Nutt

**14. MOTHER'S MAIDEN NAME**: Mary U. Armitage

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: The Medical Record — ADDRESS: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO (b) Acute multiple gastric & duodenal ulcers — 3 days

DUE TO (c) Post op state total pelvic exenteration — 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

171X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Adenocarcinoma of uterine cervix

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (☒ (this hospital) attended the deceased from February 23, 1962 to March 11, 1962, that (☒ (we) last saw the deceased alive on March 11, 1962, and that death occured at 12:40 PM, from the causes and on the date stated above.

**22a. SIGNATURE** Yosef H. Pilch, M.D. M.D.

**22b. DATE SIGNED**

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22c. PHYSICIAN'S NAME** (Type) Y osef M. Pilch, M.D.

**22d. ADDRESS** The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): burial

**23b. DATE THEREOF**: 3/14/62

**23c. NAME OF CEMETERY OR CREMATORY**: Rock Creek Cemetery

**23d. LOCATION** (City, town or county) (State): Washington, D.C.

**24. FUNERAL DIRECTOR'S SIGNATURE**: The S.H.Hines Co.,

**ADDRESS**: 2901 14th St. N.W., Wash,DC

**25a. REC'D BY REGISTRAR** DATE MAR 14 '62

**25b. REGISTRAR'S SIGNATURE** Arthur S. Hines

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03493 **CERTIFICATE OF DEATH** 03486

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 51 I 2 1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 hr. 20 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Silver Springs
d. STREET ADDRESS: 11900 Renick Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorthea — Middle: Thelma — Last: Milne
4. DATE OF DEATH: Month: March — Day: 14, — Year: 19 62
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 14, 1962
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 2 / Min. 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (County & State, or foreign country): Bethesda, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George G. Milne III
14. MOTHER'S MAIDEN NAME: Virginia Gerhold Poehlman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service): - - - -
16. SOCIAL SECURITY NO.: - - - -
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity and Immaturity
7776X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yeer 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 14, 19 62 to March 14, 19 62, that (I) (we) last saw the deceased alive on March 14, 1962, and that death occured at 6:30AM from the causes and on the date stated above.

22e. SIGNATURE: Frederic Schulaner M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 14, 1962
22c. PHYSICIAN'S NAME (Type): FREDERIC SCHULANER, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-20-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler
ADDRESS: Tyson-Wheeler Funeral Home, Rockville Pike, Rockville, Md.
25a. REC'D BY REGISTRAR DATE MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

2-002125

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03495

## CERTIFICATE OF DEATH

Item 23b, Film G309 3/21/62 jwk

03488

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Louisiana
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bossier City
d. STREET ADDRESS: 2414 Arlington Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

51

56 x 3

3. NAME OF DECEASED (Type or print): First: Joyce; Middle: Leigh; Last: Mitchell

4. DATE OF DEATH: Month: March; Day: 14; Year: 1962

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 29, 1961

9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months 3, Days 13; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (County & State, or foreign country): Louisiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Russell A. Mitchell

14. MOTHER'S MAIDEN NAME: Nannette Marshall

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give wer or dates of service): - - - -

17. INFORMANT: Mother: Mrs. Nannette Mitchell, Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease

DUE TO (b) Anomalous Pulmonary Venous Return

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

754.5

INTERVAL BETWEEN ONSET AND DEATH: 3 mo 13 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (☒ (this hospital) attended the deceased from March 1, 1962, to 14 March, 19.62 that (☒ (we) last saw the deceased alive on March 14, 1962, and that death occured at 2:20 PM from the causes and on the date stated above.

22a. SIGNATURE: M C O'Bannon M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: March 15, 1962

22c. PHYSICIAN'S NAME (Type): M. C. O'BANNON, LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Mar. 19, 1962

23c. NAME OF CEMETERY OR CREMATORY: Paries

23d. LOCATION (City, town or county) (State): Paries, Missouri

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.

25a. REC'D BY REGISTRAR DATE: MAR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1156

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03494

## CERTIFICATE OF DEATH

Items 21 & 22b, Film G309 3/15/62 iwk

03487

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 31 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: New York
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York 69X.3
d. STREET ADDRESS: 21 East 90th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Ethel; Middle: (No middle name); Last: Mittenthal

**4. DATE OF DEATH**: Month: March; Day: 8; Year: 19 62

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 6 September 1909

**9. AGE** (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Medical Secretary

**10b. KIND OF BUSINESS OR INDUSTRY**: Medical

**11. BIRTHPLACE** (County & State, or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Benjamin Rogatz

**14. MOTHER'S MAIDEN NAME**: Rosebelle Alexander

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: Not available

**17. INFORMANT**: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrythmia — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

710.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Congestive heart failure — 9 minutes

DUE TO (c) Scleroderma — 1 - 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that ~~I~~ (this hospital) attended the deceased from Feb. 5 1962, to March 8, 1962, that ~~I~~ (we) last saw the deceased alive on March 8 1962, and that death occured at 9:30 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: Thomas Vates M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: March 8, 1962

**22c. PHYSICIAN'S NAME** (Type): Thomas Vates M.D.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: 3-9-62

**23c. NAME OF CEMETERY** ~~OR CREMATORY~~: TEMPLE ISRAEL, Mt. Hope

**23d. LOCATION** (City, town or county) (State): HASTINGS-N.Y.

**24 FUNERAL DIRECTOR'S SIGNATURE**: B. Danzansky & Son
**ADDRESS**: 3501-14th St NW

**25a. REC'D BY REGISTRAR** DATE MAR 13 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03496 **CERTIFICATE OF DEATH** 03489

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 18 Silver Spring
d. STREET ADDRESS: 138 Ritchie Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print) First: Donald Middle: Henry Last: Moore.
4. **DATE OF DEATH** Month: March Day: 26 Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: ~~8-3-94~~ ~~8/1/72~~
9. AGE (In years last birthday): ~~67~~ 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Auto mechanic
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robt. Joseph Moore
14. MOTHER'S MAIDEN NAME: Reynolds, First name--Bertha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 145-07-6414
17. INFORMANT: Howard Donald Moore — Address: 4913 40th Place, Hyattsville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

| | | Interval between onset and death |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Acute heart failure | 2 hours |
| DUE TO (b) | Chronic Pulmonary Emphysema | 20 years |
| DUE TO (c) | Chronic Pulmonary Fibrosis | 20 years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

525X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/22 1962 to 3/26 1962 that (I) (we) last saw the deceased alive on 3/26 1962 and that death occurred at 7:34 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John E. Everett M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/26/62
22c. PHYSICIAN'S NAME (Type): JOHN E. EVERETT
22d. ADDRESS: 9400 Conn. Ave. Kensington

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-29-62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Suitland Prince George's Co, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond R. Flatley ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 30 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03497

## CERTIFICATE OF DEATH

03490

**1. PLACE OF DEATH**
a. COUNTY: Montgoery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kingston
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Sant.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 x 3
d. STREET ADDRESS: 2744 Branbywine St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: LILLIAN Middle: Last: MOORE

**4. DATE OF DEATH**: Month: MARCH Day: 7 Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

**8. DATE OF BIRTH**: Nov. 11, 1886

**9. AGE** (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret. Safeway Store

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Va.

**12. CITIZEN OF WHAT COUNTRY?**:

**13. FATHER'S NAME**: Samuel H. Lightfoot

**14. MOTHER'S MAIDEN NAME**: Mary A. Nelson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 578-12-0510

**17. INFORMANT**: Mrs. Darnell Crain Jr. (Same AS 2D) Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LOBAR PNEUMONIA
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c) PARALYSIS AGITANS

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from Oct. 10, 1957 to MARCH 7, 1962 that (I) (~~we~~) last saw the deceased alive on MARCH 7 1962, and that death occured at 8:45 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Hermann Lourdes M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/7/62

**22c. PHYSICIAN'S NAME** (Type): 

**22d. ADDRESS**: 5206 NORWAY CHEVY CHASE, MD

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: March 9, 1962

**23c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill

**23d. LOCATION** (City, town or county) (State): Suitland Md.

**24. FUNERAL DIRECTOR'S SIGNATURE**: Lee Funeral Home ADDRESS: Washington DC

**25a. REC'D BY REGISTRAR** DATE MAR 9 '62

**25b. REGISTRAR'S SIGNATURE**: Curtis L. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN**: The law requires that the death certificate be executed and returned to the funeral director within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03498

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03491

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 11 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 105 Sunnyside Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 105 Sunnyside Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martin; Middle: Luther; Last: Moore
4. DATE OF DEATH: Month: Mar; Day: 25; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-6-1910
9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assist to Fiscal Sec.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Treas
11. BIRTHPLACE (State or foreign country): Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Martin T. Moore
14. MOTHER'S MAIDEN NAME: Jessie Grayson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Margaret Sullivan Moore (wife) — Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage & laceration
DUE TO (b): bullet wound into skull
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted bullet wound into skull
20c. TIME OF INJURY: Month, Day, Year: 3-25 1962 — Hour: noon a.m. p.m.
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Silver Spring (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-25-62

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 3/28/62
22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
22d. LOCATION (City, town, or country) (State): Washington, D.C.

23. FUNERAL DIRECTOR: The S.H. Hines Company — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR: DATE MAR 27 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03499 Items 8, 9 & 13 Film 0313 5/17/62 mh 03492

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D.C. b. COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 5420 Connecticut NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth Middle: F. Last: MORELAND
4. DATE OF DEATH: Month: March Day: 19 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Apr. 23 1888
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housemaid
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Arthur Padgett
14. MOTHER'S MAIDEN NAME: Fannie [illegible] Pyles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Kensington Gardens

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sep 1961 to Mar 19 1962 that (I) (we) last saw the deceased alive on Mar 19 1962 and that death occurred at 8:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Thibadeau M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): ROBERT T. THIBADEAU, M.D.
22d. ADDRESS: 10609 Concord St. Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial March 22-62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Southland Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Sammons Bros. ADDRESS: 1661-gd Hope Rd S.E. Wash D.C.
25a. REC'D BY REGISTRAR DATE: MAR 21 '62
25b. REGISTRAR'S SIGNATURE: Clifford L. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03500

## CERTIFICATE OF DEATH

03493

Item 2 Film 6311 4/17/62 mh

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney, Md.
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brooke Grove Foundation

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10131 Dallas Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Christiana — Middle: Margaretta — Last: Neil

**4. DATE OF DEATH**: Month: March — Day: 2 — Year: 1962

**5. SEX**: F

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

**8. DATE OF BIRTH**: July 18, 1869

**9. AGE** (In years last birthday): 92 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Home

**11. BIRTHPLACE** (County & State, or foreign country): Shelby Co. ILL.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: George Christian Aichele

**14. MOTHER'S MAIDEN NAME**: Christiana Margaretta Metzger

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no — (If yes give war or dates of service): —

**16. SOCIAL SECURITY NO.**: Unknown

**17. INFORMANT** (Address): Brooke Grove Foundation - Olney, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Cerebro vascular Accident — 2 mo
DUE TO (c): Hypertensive C V Disease — yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4-43 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**2De. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**2Db. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**2Df.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1959 19..., to 3/2 19 62, that (I) (we) last saw the deceased alive on 2/28 1962, and that death occured at 6:45 A.M. from the causes and on the date stated above.

**22e. SIGNATURE**: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/2/62

**22c. PHYSICIAN'S NAME** (Type): C. H. Wagner

**22d. ADDRESS**: Sandy Spring, Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Removal

**23b. DATE THEREOF**: 3-2-62

**23c. NAME OF CEMETERY OR CREMATORY**: Round Hill

**23d. LOCATION** (City, town or county) (State): Traphill, North Carolina

**24 FUNERAL DIRECTOR'S SIGNATURE**: Francis H. Barber — ADDRESS: Laytonsville, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 6 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03501 **CERTIFICATE OF DEATH** 03494

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 41 Kensington
d. STREET ADDRESS: 3210 Blueford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Claire — Middle: H. — Last: Nochera
4. DATE OF DEATH: Month: March — Day: 3, — Year: 19 62

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/10/98
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas Hughes
14. MOTHER'S MAIDEN NAME: Mary Rose Gunning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no. (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Yes Unknown
17. INFORMANT: (Son) Thomas Hughes - same above — Address: same above

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured Aortic Aneurysm — 24 hr
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 51 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from MAR. 3, 1962 to MAR 3, 1962 that (we) last saw the deceased alive on MAR. 3, 1962 and that death occured at 8:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert G. Angle M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3/3/62
22c. PHYSICIAN'S NAME (Type): Robert G. Angle
22d. ADDRESS: Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/6/62
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City, town or county) (State): Silver Spring, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 7 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03502 03495

M

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 2 yrs 3 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 SILVER SPRING
d. STREET ADDRESS: 916 GIST AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

**3. NAME OF DECEASED** (Type or print): First: John Middle: Henry Last: Nolte
**4. DATE OF DEATH** Month: March Day: 28 Year: 1962

**5. SEX:** Male
**6. COLOR OR RACE:** WHITE
**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH:** Aug. 3, 1896
**9. AGE** (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Plumber
**10b. KIND OF BUSINESS OR INDUSTRY:** CONTRACTOR
**11. BIRTHPLACE** (State or foreign country): MARYLAND
**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** HENRY NOLTE
**14. MOTHER'S MAIDEN NAME:** ELIZABETH GLADMAN

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
**16. SOCIAL SECURITY NO.:** UNKNOWN
**17. INFORMANT:** HELEN R. HAUGH Address: 916 GIST AVE. SILVER SPRING MD. (SISTER)

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Bronchial asthma — ~~2~~ 2-3 yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
24 1X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ~~Coma~~ Encephalomalacia (old strokes)
**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b.** DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
**20c.** TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
**20d.** INJURY OCCURRED While at work ☐ Not while at work ☐
**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

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**21. I certify** that (I) (this hospital) attended the deceased from 3/24 1962 to 3/28 1962 that (I) (we) last saw the deceased alive on 3/27 1962 and that death occurred at 8 P. M. from the causes and on the date stated above.

**22a.** SIGNATURE: Marvin Wadler M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b.** DATE SIGNED
**22c.** PHYSICIAN'S NAME (Type): MARVIN WADLER
**22d.** ADDRESS: 8218 Wisc. Av. Bethesda, Md.

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**23a.** BURIAL, CREMATION, REMOVAL (Specify): BURIAL
**23b.** DATE THEREOF: 3/31/62
**23c.** NAME OF CEMETERY OR CREMATORY: ST. JOHNS
**23d.** LOCATION (City, town, or county) (State): FOREST GLEN MD.

**24.** FUNERAL DIRECTOR'S SIGNATURE: W W Chambers Co. ADDRESS: WASHINGTON D.C.
**25a.** REC'D BY REGISTRAR DATE MAR 30 '62
**25b.** REGISTRAR'S SIGNATURE: Clifton S. Mears

BP

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by a hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03503 **CERTIFICATE OF DEATH** 03496

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 8hrs. 10 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
d. STREET ADDRESS: 1012 Henderson Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: BABY BOY Middle: Last: OWEN

**4. DATE OF DEATH**: Month 3 – Day 17 Year 1962

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-17-62
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 8 Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): new born infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Montgomery, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Richard Owen
14. MOTHER'S MAIDEN NAME: Helen Kidwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: hospital records Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: At birth
762.0
DUE TO (b) Pulmonary Edema
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Bilateral Adrenal Cortical Atrophy

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-17, 1962 to 3-17, 1962 that (I) (we) last saw the deceased alive on 3-17 1962, and that death occured at 8:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-19-62
22c. PHYSICIAN'S NAME (Type): Jack Schumacher
22d. ADDRESS: Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/21/62
23c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
23d. LOCATION (City, town or county) (State): Boyds, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home ADDRESS: 1331 E. Montg. Ave. Rockville, Maryland
25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

2-052285

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03504

## CERTIFICATE OF DEATH

03497

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: District Of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1914 Connecticut Ave., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Zelma — Middle: Alexandra — Last: Ozols
4. DATE OF DEATH: Month: March — Day: 14, — Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 3, 1902
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Librarian
10b. KIND OF BUSINESS OR INDUSTRY: Library
11. BIRTHPLACE (County & State, or foreign country): Latvia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Bergmanis
14. MOTHER'S MAIDEN NAME: Emilie Kavpul

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 579-42-0889
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryalnd

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Hemorrhage into L. Hemithorax | 5 days |
| DUE TO (b) | Aplastic anemia | 18 months |
| DUE TO (c) | Multiple myeloma | 18 months |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
2Dc. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from September 13, 1961 to March 14, 19 62 that (I) (we) last saw the deceased alive on March 14, 19 62 and that death occured at 8:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: Marvin Lewis M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 15, 1962
22c. PHYSICIAN'S NAME (Type): Marvin Lewis, M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~
23b. DATE THEREOF: 3/17/62
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.,2901 14th St. N.W. — ADDRESS: Wash, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 19 '62
25b. REGISTRAR'S SIGNATURE: Cuthbert S. Hines

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

03505 03498

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 63 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. (D. C.)
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5626 Massachusetts Avenue NW
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wendell — Middle: Anthony — Last: Parker
4. DATE OF DEATH: Month: March — Day: 20, — Year: 19 62
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 10, 1907
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): M.D.
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (County & State, or foreign country): Lakewood, Ohio
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wendell Parker
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma, stomach
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1962, to March 20, 1962 that (I) (we) last saw the deceased alive on March 20, 1962, and that death occured at 5:45AM from the causes and on the date stated above.

22a. SIGNATURE: John W. Brackett Jr. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 20, 1962
22c. PHYSICIAN'S NAME (Type): JOHN W. BRACKETT JR.
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-23-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Humphrey Funeral Home, 7557 Wisc. Ave Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03506 **CERTIFICATE OF DEATH** 03499

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN THIS PLACE: 1 day 12 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 917 - Dale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth Middle Last Peterson

4. DATE OF DEATH: Month March Day 1 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/2/81
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): HARLAN IOWA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John O. Michael SON
14. MOTHER'S MAIDEN NAME: MARTINE NELSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Alice P. Berger Address: 917 Dale Dr, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 26, 1961 to March 1, 1962, that (I) (we) last saw the deceased alive on March 1, 1962, and that death occured at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward J. Richards M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-1-62
22c. PHYSICIAN'S NAME (Type): Edward J. Richards
22d. ADDRESS: 10,110 Georgia Ave, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-5-62
23c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fiske ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE MAR 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03507

## CERTIFICATE OF DEATH

03500

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5605 Albia Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 57 Bethesda
d. STREET ADDRESS: 5605 Albia Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EMILIE — Middle: — Last: PORTO

4. DATE OF DEATH: Month: March — Day: 19 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 22, 1894
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months 9, Days 27 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA-Nat.

13. FATHER'S NAME: Albert Musacchio
14. MOTHER'S MAIDEN NAME: Salmoa Cavalieri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Son — Address: Joseph B. Porto — Same as Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b) Cardio-Vascular Renal Sclerosis — 10 yrs+
DUE TO (c) Diabetes Severe — 5 yrs+

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 1960 19..., to March 19, 1962 that (I) (we) last saw the deceased alive on March 19 1962, and that death occured at 12 05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Dr J. D Damian M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar. 19, 1962
22c. PHYSICIAN'S NAME (Type): Jules D. Damian
22d. ADDRESS: 2741 - 34th St., N.W., Washington, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
23b. DATE THEREOF: 3/22/62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Mousoleum
23d. LOCATION (City, town or county) (State): Prince George Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS:
25a. REC'D BY REGISTRAR: DATE MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Hance

VR A15 (4)
15M 7/61

(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03508

## CERTIFICATE OF DEATH

03501

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 26 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 55 Chevy Chase
d. STREET ADDRESS: 6400 Stratford Rd.;
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Erma; Middle: S.; Last: Potts

4. DATE OF DEATH: Month: March; Day: 20; Year: 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 6-18-94
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT SHADE
14. MOTHER'S MAIDEN NAME: VIRGINIA UNGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs G.C. Williams Address: 12807 Flack St. Sil Spr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma with metastases, primary site undetermined
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1 9 9 X

INTERVAL BETWEEN ONSET AND DEATH: 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/18/62, 19..., to 3/20/62, 19..., that (I) (we) last saw the deceased alive on March 20 1962, and that death occured at 4:00 p.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert N. Coale M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: March 20, 1962
22c. PHYSICIAN'S NAME (Type): Dr. Robert N. Coale
22d. ADDRESS: 4429 Bradley Lane, Bethesda.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/23/62
23c. NAME OF CEMETERY OR CREMATORY: Mt. Hebron Cemetery
23d. LOCATION (City, town or county) (State): Winchester, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS
25a. REC'D BY REGISTRAR DATE: MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03509

## CERTIFICATE OF DEATH

03502

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 199 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Los Angeles
d. STREET ADDRESS: 1011¼ S. Harvard Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Morris — Middle: Edward — Last: Queen

4. **DATE OF DEATH**: Month: March — Day: 14, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negroid

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 5, 1937

9. AGE (In years last birthday): 24 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Service Man

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H. Queen

14. MOTHER'S MAIDEN NAME: Mary A. Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): - - - - - -

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: Hospital Records — Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Granulocytic leukemia
204.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (X) (this hospital) attended the deceased from Aug. 27, 1961 to March 14, 1962, that (X) (we) last saw the deceased alive on March 14, 1962, and that death occured at 7:10AM from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Stitcher M.D.

22b. DATE SIGNED: March 14, 1962

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): JOSEPH E. STITCHER LCDR MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-21-62

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: James E. Jenkins N.W., Washington D.C.
JOHNSON & JENKINS FUNERAL HOME, 4804 Ga. Ave.

25a. REC'D BY REGISTRAR DATE MAR 20 '62

25b. REGISTRAR'S SIGNATURE: Clifford E. Krause

M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03510 03503

**1. PLACE OF DEATH**
a. COUNTY: Montgomery Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 27 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 5910 Ridgway Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: William James; Middle: ~~Baby Boy~~; Last: Ray

**4. DATE OF DEATH**: Month: Mar.; Day: 3; Year: 19 62

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 3/2/62

**9. AGE** (In years last birthday): yrs.; IF UNDER 1 YEAR: Months: ; Days: 1; IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired):

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Montgomery Gen. Hosp.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Robert S. Ray

**14. MOTHER'S MAIDEN NAME**: Barbara Tough

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): no
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Hospital Records
Address:

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
DUE TO (b) Congenital Heart Disease
DUE TO (c) Interventricular Septum Defect - Incomplete, rotation of aorta

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

754.2

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Situs Inversus (Complete)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY**: Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED**: While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.):

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3/2 19 62 to 3/3 19 62, that (I) (we) last saw the deceased alive on 3/3 19 62, and that death occured at 3:15 P.M., from the causes and on the date stated above.

**22a. SIGNATURE**: C H Ligon M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/4/62

**22c. PHYSICIAN'S NAME** (Type): Dr. C.H. Ligon

**22d. ADDRESS**: Sandy Spring, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/6/62

**23c. NAME OF CEMETERY OR CREMATORY**: Parklawn

**23d. LOCATION** (City, town or county) (State): Rockville, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 8 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

2-052257

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03511 03504

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29 Silver Spring
d. STREET ADDRESS: 607 Dartmouth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: James — Middle: Gordon — Last: Reidinger

**4. DATE OF DEATH**: Month: March — Day: 27, — Year: 19 62

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: November 23, 1919

**9. AGE** (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Superintendant

**10b. KIND OF BUSINESS OR INDUSTRY**: Northwood HighSchool Maintenance

**11. BIRTHPLACE** (County & State, or foreign country): Anniston, Alabama

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Gordon M. Reidinger

**14. MOTHER'S MAIDEN NAME**: Saidie ~~Sadie~~ Scheid

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.**: 423-07-0122 ~~Unavailable~~

**17. INFORMANT**: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO (b) Congestive Heart failure, [redacted] — Undetermined
DUE TO (c) Chronic Glomerulonephrit[redacted] — Undetermined

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

592

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

**20c.** TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

**20d.** INJURY OCCURRED: While at work ☐ Not While at work ☐

**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 21, 19 62 to March 27, 19 62 that (I) (we) last saw the deceased alive on March 27 19 62, and that death occured at 5:20 A.M., from the causes and on the date stated above.

**22a.** SIGNATURE: Norman H. Bell M.D. — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22b.** DATE SIGNED: March 27, 1962
**22c.** PHYSICIAN'S NAME (Type): Norman H. Bell, M.D.
**22d.** ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Burial
**23b.** DATE THEREOF: 3-29-62
**23c.** NAME OF CEMETERY OR CREMATORY: Highland Cemetery
**23d.** LOCATION (City, town or county) (State): Anniston Calhoun Co, Alabama

**24** FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zika — ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
**25a.** REC'D BY REGISTRAR DATE: MAR 29 '62
**25b.** REGISTRAR'S SIGNATURE: Clifford L. Morris

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

[redacted]

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# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03512 **CERTIFICATE OF DEATH** 03505

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3yr. 10 mos 24 dy
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Congressional Manor Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 128 South Adams Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth; Middle: ; Last: Rice

4. DATE OF DEATH: Month: MAR; Day: 14; Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 18 1869
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Rice
14. MOTHER'S MAIDEN NAME: Alberta Tschiffely

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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Julia M. Walter-Neice-Wash. D. C. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Generalized & cerebral arteriosclerosis — 10+ years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
334X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from April 4 1958 to March 14 1962 that (I) (we) last saw the deceased alive on March 7 1962 and that death occurred at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: G. Bowditch Hunter, Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Mar. 14, 1962
22c. PHYSICIAN'S NAME (Type): G. Bowditch Hunter, Jr., M.D.
22d. ADDRESS: 809 Veirs Mill Rd., Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/16/62
23c. NAME OF CEMETERY OR CREMATORY: Darnestown Cemetery
23d. LOCATION (City, town, or county) (State): Darnestown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 16 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03513 **CERTIFICATE OF DEATH** 03506

Item 23b Film 0310 4/2/62 mh

**1. PLACE OF DEATH** e. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 5 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)

a. STATE: Maryland — b. COUNTY: Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi

d. STREET ADDRESS: 10506 Edgemont Dr.

a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: Stanley — Middle: Schreiber — Last: Ricker

**4. DATE OF DEATH**: Month: March — Day: 25 — Year: 1962

5. SEX: Male — 6. COLOR OR RACE: Caucasian — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 3, 1919 — 9. AGE (In years last birthday): 43 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Naval Officer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert B. Ricker

14. MOTHER'S MAIDEN NAME: Lena Perry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give were or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: WIFE: Mrs. Pauline F. Ricker Same as #2 — Address:

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatic failure

DUE TO (b): Hemorrhagic peritonitis of ascites

DUE TO (c): Metastatic carcinoma of colon — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 21, 1962, to March 25, 1962, that (I) (we) last saw the deceased alive on March 25, 1962, and that death occured at 0645 AM from the causes and on the date stated above.

22a. SIGNATURE: William P. Baker M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: March 25, 1962

22c. PHYSICIAN'S NAME (Type): WILLIAM P. BAKER LT MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Mar. 28, 1962

23c. NAME OF CEMETERY OR CREMATORY: NATIONAL CEMETARY

23d. LOCATION (City, town or county) (State): ARLINGTON, VA.

24 FUNERAL DIRECTOR'S SIGNATURE: S. H. Hines Co. — ADDRESS: 2901 14th St. N.W. W.D.C.

S.H.HINES CO.FUNERAL HOME 2901 14TH ST NW WDC

25a. REC'D BY REGISTRAR DATE: MAR 27 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Hanna

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03514

## CERTIFICATE OF DEATH

Reg. Dist. No. 23507

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 17 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. (If institution, state last place of residence before entering institution.)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES ~~MONTGOMERY~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK 1652-2
d. STREET ADDRESS: 6618 Poplar Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE — Middle ROSE — Last ROBERTSON

4. DATE OF DEATH: Month 3 — Day 31 — Year 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-25-85
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WASHINGTON, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Christian Keiner
14. MOTHER'S MAIDEN NAME: Caroline (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Kenneth R. Robertson — Address 6109 Wilmett Rd. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1) Coronary Thrombosis — Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) 2) Chronic Coronary Arteriosclerosis — Undetermined
DUE TO (c) 3) Arterial Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteo-Arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 1, 19 62, to Mar 31, 19 62 that I last saw the deceased alive on Mar 31, 19 62, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George L Ball M.D. — ADDRESS (Street, city or town, state): 10620 Georgia Ave — DATE SIGNED: Mar 31, 1962

PHYSICIAN'S NAME (Type): George L Ball — Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-3-1962
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collin — ADDRESS: 3821-14th St NW Wash. D. C.
24a. REC'D BY REGISTRAR — DATE: APR 4 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03515 **CERTIFICATE OF DEATH** 03508

**1. PLACE OF DEATH**
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS: RFD # 1, Box 193B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Charles Middle: Augustus Last: Robinson

**4. DATE OF DEATH** Month: March Day: 5 Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Nov. 17, 1882

**9. AGE** (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Architect

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Salamanaca, N.Y.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: George Henry Robinson

**14. MOTHER'S MAIDEN NAME**: Jessie Crocker

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: 276-16-5311

**17. INFORMANT**: Miss Alice L. Robinson, Item 2
Address:

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Lobular Pneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 1 week.
4 4 X
DUE TO (b) Advanced cerebral arteriosclerosis with multiple thrombi and encephalomalacia — 5 years
DUE TO (c) Severe arteriosclerotic cardio-vascular-renal disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20e. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.): No injury

**20c. TIME OF INJURY** Month, Day, Year: Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.):

**20f.** (City or town) (County) (State)

**21. I certify** that (I) ~~(this hospital)~~ attended the deceased from 1954, 19..., to March 5, 1962, that (I) ~~(we)~~ last saw the deceased alive on March 5, 1962, and that death occured at 5:20AM, from the causes and on the date stated above.

**22a. SIGNATURE**: M. McKendree Boyer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/5/62

**22c. PHYSICIAN'S NAME** (Type): M. McKendree Boyer, M. D.

**22d. ADDRESS**: 9830 Main Street Damascus, Maryland.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/8/62

**23c. NAME OF CEMETERY OR CREMATORY**: Acacia Park Cemetery

**23d. LOCATION** (City, town or county) (State): Mayfield Heights, Ohio.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Olin L. Mobsmith

ADDRESS: Damascus, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 7 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03516 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03509

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 27 hrs 5 mins
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kensington
d. STREET ADDRESS: 11107- Newport Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carme la Middle: Motta Last: Romeo
4. DATE OF DEATH: Month: March Day: 16 Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/9/1900
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CATANIA ITALY
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ANTONIA MOTTA
14. MOTHER'S MAIDEN NAME: GRAZIA CHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joe Romeo. Address: 11107 Newport Mill Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: sudden
812 X
DUE TO (b) Multiple fractures
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Ran over by auto — 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian - Ran over by own car
20c. TIME OF INJURY Hour: 12:05 p.m. Month, Day, Year: 3-15 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): driveway
20f. (City or town): Kensington (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: Mar 17, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 20 MAR 1962
22c. NAME OF CEMETERY OR CREMATORY: H. Lincoln Mausoleum
22d. LOCATION (City, town, or county): PR Geo Cty (State): Md.

23. FUNERAL DIRECTOR: Rinaldi Funeral Home
ADDRESS: 7400 Ga Ave NW Wash D.C.
24a. REC'D BY REGISTRAR DATE: MAR 21 '62
24b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03517 **CERTIFICATE OF DEATH** 03510

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Bethesda
d. STREET ADDRESS: 4806 Middlesex Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Alfio; Middle: Ronsisvalle; Last:

**4. DATE OF DEATH**: Month: March; Day: 14; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: May 3, 1888

**9. AGE** (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: 10; Days: 11

IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY**: Barbering

**11. BIRTHPLACE** (County & State, or foreign country): Italy

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Joseph Ronsisvalle

**14. MOTHER'S MAIDEN NAME**: Concetta Emanuele

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: 577-18-4013

**17. INFORMANT**: Maria (wife) — Address: Same as above

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO (b): Ruptured Diverticulum, Sigmoid Colon — 9 days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

572.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

MEDICAL CERTIFICATION

**21. I certify** that (I) (this hospital) attended the deceased from Mar 4, 1962 to Mar 14, 1962 that (I) (~~we~~) last saw the deceased alive on Mar 14 1962 and that death occured at 8:34 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: John P. Haberline M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: Mar 14 1962
**22c. PHYSICIAN'S NAME** (Type): John P. Haberline
**22d. ADDRESS**: 1015 Spring St Silver Spring Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3/17/62
**23c. NAME OF CEMETERY OR CREMATORY**: Gate of Heaven Cem.
**23d. LOCATION** (City, town or county) (State): Silver Spring, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
**25a. REC'D BY REGISTRAR** DATE MAR 16 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Travis

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03518 **CERTIFICATE OF DEATH** 03511

Items 1c, 7 & 14 Film G309 3/29/62 iwk

**1. PLACE OF DEATH**
e. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 530 536 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: ~~Baltimore~~
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 5901 Simmonds Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 vol. 4

**3. NAME OF DECEASED** (Type or print): First: David; Middle: N; Last: Rudin

**4. DATE OF DEATH**: Month: March; Day: 18; Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☒ Divorced

**8. DATE OF BIRTH**: December 3, 1905

**9. AGE** (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Physician

**10b. KIND OF BUSINESS OR INDUSTRY**: Medicine

**11. BIRTHPLACE** (County & State, or foreign country): Russia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Nisson Rudin

**14. MOTHER'S MAIDEN NAME**: Pauline ~~((Last name unknown))~~ Zeldin

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): YES
(If yes give war or dates of service): WW II

**16. SOCIAL SECURITY NO.**: 448-26-1018

**17. INFORMANT**: The Medical Records
Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary infarction — INTERVAL BETWEEN ONSET AND DEATH: 18 Hours
DUE TO (b): Multiple myeloma — 3 Years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

20 SX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from October 4, 1960 to March 18, 1962 that (I) (we) last saw the deceased alive on March 18, 1962, and that death occured at 5:05 PM from the causes and on the date stated above.

**22a. SIGNATURE** J. L. Fahey M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22b. DATE SIGNED** 3/18/62
**22c. PHYSICIAN'S NAME** (Type): John L. Fahey M.D.
**22d. ADDRESS**: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: March 19, 1962
**23c. NAME OF CEMETERY OR CREMATORY**: Beth Tfiloh Cemetery
**23d. LOCATION** (City, town or county) (State): Baltimore, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE**: SOL LEVINSON & BROS. INC.
**ADDRESS**: 6010 Reisterstown Rd.

**25a. REC'D BY REGISTRAR** DATE: MAR 20 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03519 **CERTIFICATE OF DEATH** 03512

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Bethesda
d. STREET ADDRESS: 4858 Battery Lane,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: James Middle: V. Last: Sammartino

**4. DATE OF DEATH** Month: March Day: 24th. Year: 1962

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒* **DIVORCED** ☐

**8. DATE OF BIRTH:** 6/24/89

**9. AGE** (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY:** Supt.-Air Plane Parts Plant

**11. BIRTHPLACE** (County & State, or foreign country): Italy

**12. CITIZEN OF WHAT COUNTRY?** Naturalized U.S.A 50 yrs.

**13. FATHER'S NAME:** Vincent Sammartino

**14. MOTHER'S MAIDEN NAME:** Antoinette (Unknown)

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) No (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.:** 103-14-4621

**17. INFORMANT:** Daughter Mrs. Alberta Linn Address: Same as above.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (b) Coronary Arteriosclerotic Ht. Disease - Myocard. Infarction - 1 year
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year Hour a.m. p.m. 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from December, 1960 to March 24, 1962 that (I) (we) last saw the deceased alive on March 24 1962, and that death occured at 9:40 A.M. from the causes and on the date stated above.

**22a. SIGNATURE** James W. Egan M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED** 3-25-62

**22c. PHYSICIAN'S NAME** (Type) Dr. James W. Egan

**22d. ADDRESS** 9911 Old Spring Rd., Kensington, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial-transit 3-26-62

**23b. DATE THEREOF**

**23c. NAME OF CEMETERY OR CREMATORY:** St. Mary's Cemetery

**23d. LOCATION** (City, town or county) (State): Lawrence, New York

**24 FUNERAL DIRECTOR'S SIGNATURE:** ROBERT A. PUMPHREY ADDRESS: Bethesda, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 27 '62

**25b. REGISTRAR'S SIGNATURE** Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03520 Items 1c, & 2 Film G308 3/12/62 03513

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 46 years-3 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Chestnut Lodge

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: ~~Maryland~~ Wash.D.C. — b. COUNTY: ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Rockville~~ Washington, D.C.
d. STREET ADDRESS: unknown ~~500 N. Montgomery Avenue~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First MARGUERITE — Middle — Last SAWYER

**4. DATE OF DEATH**: Month March — Day 2 — Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: ? 1874
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Lucius Sawyer
14. MOTHER'S MAIDEN NAME: Elizabeth M. Ricker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Records — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema

450.0

DUE TO (b) Congestive heart failure

DUE TO (c) General arterioslerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/1/, 1961, to 3/2/, 1962, that (I) (we) last saw the deceased alive on 2/21 1962, and that death occured at 8 p.M, from the causes and on the date stated above.

22a. SIGNATURE: Dexter M Bullard M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: Mar. 3, 1962
22c. PHYSICIAN'S NAME (Type): DEXTER M. BULLARD, M.D.
22d. ADDRESS: Falls Rd., Rockville, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
23b. DATE THEREOF: March 7, 1962
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek
23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Montg. Ave Rockville, Maryland
25a. REC'D BY REGISTRAR: DATE MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03521 03514

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Illinois
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Peoria
d. STREET ADDRESS: 6918 North Wilshire Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

51X·3

3. NAME OF DECEASED (Type or print): First: Ralph — Middle: William — Last: Schmitt

4. DATE OF DEATH: Month: March — Day: 27, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 15, 1920

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Contractor

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Aaron Schmitt

14. MOTHER'S MAIDEN NAME: Jennie Decker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 329-12-7789

17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Multiple focal hemorrhages in brain | 4 hours |
| DUE TO (b) | Right pleural effusion, right hemothorax | 2 weeks |
| DUE TO (c) | Acute leukemia with hepatomegaly, splenomegaly | 8 weeks |

204.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 23, 19 62 to March 27, 19 62, that ☒ (we) last saw the deceased alive on March 27, 19 62, and that death occured at 8:20PM from the causes and on the date stated above.

22a. SIGNATURE: J. David Heywood M.D.

22b. DATE SIGNED: 3/28/62 — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): J. David Heywood, M.D.

22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transit-Burial

23b. DATE THEREOF: 3/28/62

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Cemetery

23d. LOCATION (City, town or county) (State): Peoria, Illinois

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: MAR 30 '62

25b. REGISTRAR'S SIGNATURE: Clarence S. Kraus

VR A15-(4) 15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03522 **CERTIFICATE OF DEATH** 03515

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 623-Gist Ave.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 24
d. STREET ADDRESS: 623 Gist Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lottie Middle: Lucetta Last: Schorr
4. DATE OF DEATH: Month: March Day: 8 Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 18 1886
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John William Whitmere
14. MOTHER'S MAIDEN NAME: Lydia Anne Olinger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): -- (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John W. Schorr Address: 7305-Willow Ave T.P.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b) Hypertensive Cardiovascular Disease — 6-8 yrs.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from ....., 1954 to 3/8, 1962, that (I) (~~we~~) last saw the deceased alive on 3/8 1962, and that death occured at 10 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Charles E. Woodson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/8/62
22c. PHYSICIAN'S NAME (Type): CHARLES E. WOODSON
22d. ADDRESS: 1801 Eye St. N.W. Wash. 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/12/62
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.
ADDRESS: 2901 14th St., N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03523 Item 23b, Film G309 3/16/62 1wk

## CERTIFICATE OF DEATH

03516

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 40 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lowell 70 X 3
d. STREET ADDRESS: Box 95
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donna; Middle: Lynn; Last: Scott
4. DATE OF DEATH: Month: March; Day: 12; Year: 1962
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 21, 1962
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months 1, Days 20 IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Gus E. Scott
14. MOTHER'S MAIDEN NAME: Edna Ann Falls
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: - - - - -
17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTHROGRYPOSIS MULTIPLEX CONGENITA

758.6

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Feb. 1, 1962, to March 12, 1962 that ☒ (we) last saw the deceased alive on March 12, 1962 and that death occured at 10 A.M./P.M. from the causes and on the date stated above.

22a. SIGNATURE: Bernard H. Feldman M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: March 13, 1962
22c. PHYSICIAN'S NAME (Type): BERNARD H. FELDMAN LT MC USN
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: March 15, 1962
23c. NAME OF CEMETERY OR CREMATORY: Gaston Memorial
23d. LOCATION (City, town or county) (State): Gastonia, North Carolina

24. FUNERAL DIRECTOR'S SIGNATURE: Charles W. Johnson ADDRESS: Rinaldi Funeral Home, 7400 Georgia Ave., WDC

25a. REC'D BY REGISTRAR DATE MAR 14 '62
25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

2170

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03524 **CERTIFICATE OF DEATH** 03517

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westhaven
d. STREET ADDRESS: 5110 Brookview Drive
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Charles — Middle: Edward — Last: Sebastian, Sr.

**4. DATE OF DEATH**: Month: March — Day: 3 — Year: 1962

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 9/12/1880

**9. AGE** (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret. Bureau Engraving

**10b. KIND OF BUSINESS OR INDUSTRY**: U. S. Gov't

**11. BIRTHPLACE** (County & State, or foreign country): Washington, D. C.

**12. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**13. FATHER'S NAME**: Edward Sebastian

**14. MOTHER'S MAIDEN NAME**: Roberta Dyer

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no — (If yes give were or dates of service)

**16. SOCIAL SECURITY NO.**: none

**17. INFORMANT**: Charles E. Sebastian, Jr. — Address: 5110 Brookview Dr. Westhaven, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO (b) Coronary Arteriosclerosis
DUE TO (c) Generalized Arteriosclerosis
420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1/10/, 1959, to 3/3/, 1962 that (I) (we) last saw the deceased alive on 3/2/, 1962 and that death occured at 9:20 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: E. Stuart Lyddane, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): E. Stuart Lyddane, M.D.

**22d. ADDRESS**: 3066 - Quart. N. W.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3/6/62

**23c. NAME OF CEMETERY OR CREMATORY**: Oak Hill Cemetery

**23d. LOCATION** (City, town or county) (State): Washington, D. C.

**24 FUNERAL DIRECTOR'S SIGNATURE**: The S. H. Hines Co. — ADDRESS: Washington, D. C.

**25a. REC'D BY REGISTRAR** DATE: MAR 5 '62

**25b. REGISTRAR'S SIGNATURE**: Clifton L. Hines

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03525

## CERTIFICATE OF DEATH

03518

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 104 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: North Carolina — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Concord — 70x·3
d. STREET ADDRESS: 254 N. Church St.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Marvin — Middle: Walter — Last: SECHLER

**4. DATE OF DEATH**: Month: March — Day: 1 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8 November 1939
9. AGE (In years last birthday): 22 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Marshall Sechler
14. MOTHER'S MAIDEN NAME: Hedgie Wray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mother: Hedgie Sechler

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rhabdomyosarcoma, retroperitoneal — INTERVAL BETWEEN ONSET AND DEATH: 18 mo

197.9

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED — While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 17 November 1961 to 1 March, 1962, that (I) (we) last saw the deceased alive on 1 March 19 62, and that death occured at 4:15 PM from the causes and on the date stated above.

22a. SIGNATURE: A.T. Thorp Jr. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2 March 1962
22c. PHYSICIAN'S NAME (Type): A.T. THORP, LCDR MC USN
22d. ADDRESS: U.S. NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/6/62
23c. NAME OF CEMETERY OR CREMATORY: Carolina Memorial
23d. LOCATION (City, town or county) (State): Concord, North Carolina

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler — ADDRESS: Rockville Pike, Rockville, Md.
Tyson Wheeler Funeral Home 1331 E. Montgomery Ave.
25a. REC'D BY REGISTRAR — DATE MAR 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

(M)

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03526

## CERTIFICATE OF DEATH

03519

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 107 Dawson Avenue

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Rockville
d. STREET ADDRESS: 107 Dawson Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First ROBERT Middle GRANT Last SHAW

**4. DATE OF DEATH**: Month March Day 10, Year 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 6/19/89

**9. AGE** (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Ret. Carpenter

**10b. KIND OF BUSINESS OR INDUSTRY**: Building

**11. BIRTHPLACE** (County & State, or foreign country): Scotland

**12. CITIZEN OF WHAT COUNTRY?**: Scotland ✓

**13. FATHER'S NAME**: Unknown

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: 579-48-4629

**17. INFORMANT**: Marion S. Shaw-Item # 2
Address:

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arteriosclerosis, left hemiplegia. — 10 years
DUE TO (c):

Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

321 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

2De. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 1950, ~~19~~, to March 10, 1962, that (I) (~~we~~) last saw the deceased alive on March 10 1962, and that death occured at ~~8:15 P.M.~~ from the causes and on the date stated above.

22a. SIGNATURE: Wm A. Linthicum, M.D. — M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/10/62

22c. PHYSICIAN'S NAME (Type): Wm A. Linthicum

22d. ADDRESS: 110 S Washington St., Rockville, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Cremation

**23b. DATE THEREOF**: 3/13/62

**23c. NAME OF CEMETERY OR CREMATORY**: Ft. Lincoln

**23d. LOCATION** (City, town or county) (State): Prince George Co., Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland

**25a. REC'D BY REGISTRAR** DATE MAR 13 '62

**25b. REGISTRAR'S SIGNATURE**: Clifton L. Kime

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03527

## CERTIFICATE OF DEATH

03520

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2600 Terrapin Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2600 Terrapin Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

34 / 1

3. NAME OF DECEASED (Type or print): First: EVA — Middle: LEONA — Last: SHERMAN

4. DATE OF DEATH: Month: March — Day: 24 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 20, 1886

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Month ~~2~~ Days ~~4~~ — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Ryder

14. MOTHER'S MAIDEN NAME: Juliet Sprague

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 477-16-4883D

17. INFORMANT: Mrs. Charles Preston — Address: 2600 Terrapin Rd. S.S. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Hemorrhagic Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Severe Rheumatoid Arthritis
DUE TO (c): Treated with Cortisone — 3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7220

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 1 1959 to March 24 1962 that (I) (~~we~~) last saw the deceased alive on Mar 24 1962 and that death occurred at 8 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John J. Curry, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3/24/62

22c. PHYSICIAN'S NAME (Type): JOHN J. CURRY

22d. ADDRESS: 10620 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/28/62

23c. NAME OF CEMETERY OR CREMATORY: CRYSTAL LAKE CEMETERY

23d. LOCATION (City, town, or county): MINNEAPOLIS — (State): MINNESOTA

24. FUNERAL DIRECTOR'S SIGNATURE: Stephen A. Zska — ADDRESS: 8434 Georgia Ave. — WARNER E. PUMPHREY INC SILVER SPRING, MARYLAND

25a. REC'D BY REGISTRAR: MAR 27 '62 — DATE

25b. REGISTRAR'S SIGNATURE: Clifford S. Mauro

VR A15 (4)
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03528 **CERTIFICATE OF DEATH** 03521

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**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Marylnd
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt,
d. STREET ADDRESS: 2 Empire Place, 1667.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Shoemaker
4. DATE OF DEATH: Month: March — Day: 6, — Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 6, 1962
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months — Days: IF UNDER 24 HRS.: Hours — Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Edison Shoemaker
14. MOTHER'S MAIDEN NAME: Betty Joyce Matney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: father — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 10 min

761.6

DUE TO (b) TIGHT LOOP CORD AROUND NECK — 10 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: Harold Sterling M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/6/62
22c. PHYSICIAN'S NAME (Type): Harold Sterling
22d. ADDRESS: 1352 Ennis Blvd

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 3-6-62
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital, Takoma Park, Md. (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D. — ADDRESS: Washington San. & Hospital
25a. REC'D BY REGISTRAR DATE: MAR 8 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2-006303

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03529 **CERTIFICATE OF DEATH** 03522

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed [redacted] 24 hours after death. Page 4 [redacted] be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church — 83X·3
d. STREET ADDRESS: 1224 West Greenstead Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: Mae; Last: Shupe
4. DATE OF DEATH: Month: March; Day: 17; Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 22, 1926
9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lester Craig
14. MOTHER'S MAIDEN NAME: Pearl Craig

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 228-28-4986
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH

593X

DUE TO (b) Auricular flutter — 1 1/2 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Renal failure — 13 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Primary hyperparathyroidism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 2, 1962 to March 17, 1962, that ☒ (we) last saw the deceased alive on March 17 1962, and that death occured at 10:40PM, from the causes and on the date stated above.

22a. SIGNATURE: Albert Ayerst Carr M.D.
22b. DATE SIGNED: 3/18/62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Albert Ayerst Carr, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

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23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/20/62
23c. NAME OF CEMETERY OR CREMATORY: Spoon Creek Cemetery
23d. LOCATION (City, town or county) (State): Critz, Patrick Co. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

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FOR STATE HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03530

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03523

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. San. & Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Silver Spring
d. STREET ADDRESS: 175 E. Wayne Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Fanny; Middle: (nmn); Last: Siegel

**4. DATE OF DEATH**: Month: 3; Day: 2; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: Wh.

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Apr 10 – 1891

**9. AGE** (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY**: –

**11. BIRTHPLACE** (State or foreign country): Russia

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: Samuel Friedman

**14. MOTHER'S MAIDEN NAME**: Annie Glass

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service): –

**16. SOCIAL SECURITY NO.**: NONE

**17. INFORMANT**: Daughter – Mrs. Sally Goldstein, Address (same as 2d above)

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

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**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: Mar 2 1962

**22a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**22b. DATE THEREOF**: 3/4/1962
**22c. NAME OF CEMETERY OR CREMATORY**: NAT'L. MEM. PARK
**22d. LOCATION** (City, town, or country) (State): FALLS CHURCH, VA.

**23. FUNERAL DIRECTOR**: Hadley Funeral Home
ADDRESS: 4217-9th Street

**24a. REC'D BY REGISTRAR** DATE MAR 5 '62
**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death, if any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/6D

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03531 **CERTIFICATE OF DEATH** 03524

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6005 Landon Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Hope — Middle: Dalberta — Last: Slone

**4. DATE OF DEATH**: Month: March — Day: 14 — Year: 19 62

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Dec. 19, 1905

**9. AGE** (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months: 2, Days: 25 — IF UNDER 24 HRS.: Hours: , Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: ----------

**11. BIRTHPLACE** (County & State, or foreign country): Ohio

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: W. J. Hewitt

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give year or dates of service):

**16. SOCIAL SECURITY NO.**: Unknown

**17. INFORMANT**: Horace E. Slone-Husband-same 2d — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Uremia | 4 days |
| DUE TO (b) | Dehydration + starvation from Pyloric obst. | 2 weeks |
| DUE TO (c) | Carcinoma of Pancreas | 8 months |

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 11 July, 1961, to 14 March, 1962, that (I) (we) last saw the deceased alive on 13 March 1962, and that death occured at 12:55 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: John G. Ball M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/14/62

**22c. PHYSICIAN'S NAME** (Type): John G. Ball

**22d. ADDRESS**: Bethesda, Maryland

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial-Transit

**23b. DATE THEREOF**: 3/17/62

**23c. NAME OF CEMETERY OR CREMATORY**: Sandyville Cemetery

**23d. LOCATION** (City, town or county) (State): Sandyville, Ohio

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 16 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03532 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03525

Item 9 Film G309 3/21/62 jwk

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2½ days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 Silver Spring
d. STREET ADDRESS: Beltsville Rd. 1 Box 76 Colesville/
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Everett Middle: L. Last: Smith

**4. DATE OF DEATH** Month: March Day: 14 Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Col.

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 9/2/28

**9. AGE** (In years last birthday): 33/34 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Farm Work

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Walter Smith

**14. MOTHER'S MAIDEN NAME**: Evelyn Warner

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Walter Smith, father Address: same as above

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral & pulmonary edema
DUE TO (b) Smoke inhalation
DUE TO (c) 3rd degree burns - Chest + upper extrem.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

916.0

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute pancreatitis

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. EXTERNAL CAUSE WAS PRIMARY** ☒ **or CONTRIBUTING** ☐ **CAUSE OF DEATH.**

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.): Bed + clothing caught afire while smoking

**20c. TIME OF INJURY** Hour ~~a.m.~~ p.m. 7:45 Month, Day, Year 3-11 1962

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☒

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): Home

**20f.** (City or town) Silver Spring (County) Mont. (State) Md.

**21. I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschart

Address (Street, city, town, or county):

DATE SIGNED: 3-15-62

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**22b. DATE THEREOF**: 3/17/62

**22c. NAME OF CEMETERY OR CREMATORY**: Good Hope.,

**22d. LOCATION** (City, town, or country) (State): Colesville, Md.

**23. FUNERAL DIRECTOR**: Robert L. Snowden. ADDRESS: Rockville, Md.

Robert L. Snowden

**24a. REC'D BY REGISTRAR** DATE MAR 19 '62

**24b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03533 **CERTIFICATE OF DEATH** 03526

M

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Md. b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4136 - Leland St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Irene Middle: B. Last: Smith

**4. DATE OF DEATH** Month: 3 Day: 19 Year: 1962

**5. SEX**: Female **6. COLOR OR RACE**: White **7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 1/26/85

**9. AGE** (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Practical Nurse private

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Washington D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

I

**13. FATHER'S NAME**: William T. Burdine

**14. MOTHER'S MAIDEN NAME**: Susie Faunce Wagner

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**: 301-10-9845

**17. INFORMANT**: Adelia T. Downey Address: Same Above.

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforation Small Bowel — INTERVAL BETWEEN ONSET AND DEATH: 46 hours

S61.5

DUE TO (b) Strangulated Hernia in Obturator Foramen — 5 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.): —

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): —

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (~~this hospital~~) attended the deceased from 3-14, 1962 to 3-19, 1962 that (I) (~~we~~) last saw the deceased alive on 3-19 1962 and that death occured at 2:20 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: P. P. Andrews M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3-19-62

**22c. PHYSICIAN'S NAME** (Type): P. P. Andrews

**22d. ADDRESS**: 4201 Fessenden St. N. W., Wash DC

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial **23b. DATE THEREOF**: 3/22/62 **23c. NAME OF CEMETERY OR CREMATORY**: Arlington Cemetery **23d. LOCATION** (City, town or county) (State): Arlington, Virginia

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 22 62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed [illegible] 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03534

## CERTIFICATE OF DEATH

03527

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 2 yrs 5 mos.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Waverley Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47X3
d. STREET ADDRESS: 2301 Conn AVE N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Mildred — Middle: Duvall — Last: Smoot

**4. DATE OF DEATH**: Month: March — Day: 16 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 3/6/1896

**9. AGE** (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Montg. Cty, School Teacher

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Washington, D.C.

**12. CITIZEN OF WHAT COUNTRY?**: U S A

**13. FATHER'S NAME**: Nelson H askell Duvall

**14. MOTHER'S MAIDEN NAME**: Georganne Williams

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**: 219-36-7655 UNKNOWN

**17. INFORMANT**: Nephew — Address: Richard Kudlich, Kensington, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident
DUE TO (b): Hypertension.
DUE TO (c):
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Oct 16, 1959 to March 16, 1962 that (I) (~~we~~) last saw the deceased alive on March 15 1962, and that death occured at 12:05 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: C J Everding, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3/16/62

**22c. PHYSICIAN'S NAME** (Type): C. J. Everding

**22d. ADDRESS**: 4401 East-West Highway, Beth. Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Cremation

**23b. DATE THEREOF**: 3/16/62

**23c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill Crematory

**23d. LOCATION** (City, town or county) (State): Suitland, Maryland

**24 FUNERAL DIRECTOR'S SIGNATURE** / ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 19 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur E. Hines

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03535 03528

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Olney
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Silver Spring
d. STREET ADDRESS: 2215 Kimball Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laird — Middle: Wingate — Last: Snell
4. DATE OF DEATH: Month: March — Day: 24 — Year: 1962
5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 30 1870
9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clergyman
10b. KIND OF BUSINESS OR INDUSTRY: Religion
11. BIRTHPLACE (County & State, or foreign country): Minne
12. CITIZEN OF WHAT COUNTRY?: US
13. FATHER'S NAME: William Snell
14. MOTHER'S MAIDEN NAME: Elizabeth Faye
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give year or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: W. Wingate Snell — Address: 2215 Kimball ave Sil Sp Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteriosclerotic Heart Disease — YRS
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1959 to March 24 1962, that (I) (we) last saw the deceased alive on 3-20 1962, and that death occured at 6:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: C. H. Ligon M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/24/62
22c. PHYSICIAN'S NAME (Type): C. H. Ligon
22d. ADDRESS: Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANSIT-BURIAL 3/25/62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: FAIRHOPE CEMETERY
23d. LOCATION (City, town or county) (State): FAIRHOPE, BALDWIN CO., ALABAMA

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zissa — ADDRESS: WARNER E. PUMPHREY, INC., SILVER SPRING, MD.

25a. REC'D BY REGISTRAR — DATE: MAR 30 '62
25b. REGISTRAR'S SIGNATURE: Chalmer L. Thomas

1
FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03536 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03529

Item 1h Film G308 3/9/62

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 7 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Belmont Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 11514 Georgia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Abraham — Middle: Solomon — Last:
4. DATE OF DEATH: Month: Mar — Day: 1 — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-16-73
9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher (Retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DC.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Eli Solomon
14. MOTHER'S MAIDEN NAME: Cecelia (Unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 578-12-0598
17. INFORMANT: Nursing Home Record — Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — months
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 3-1-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-5-62
22c. NAME OF CEMETERY OR CREMATORY: Wash. Hebrew Congregation
22d. LOCATION (City, town, or country): Wash. (State): D.C.

23. FUNERAL DIRECTOR: Francis J. Collins — ADDRESS: 3821-14th St. N.W. Wash. D.C.
24a. REC'D BY REGISTRAR: DATE MAR 5 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03537 03530

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 1654.2
d. STREET ADDRESS: 8100 Hammond Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle J. Last SOUDER
4. DATE OF DEATH: Month March Day 27 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-8-92
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Govt. - Retired Photo Engraver-Army Map Service
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph A. Souder
14. MOTHER'S MAIDEN NAME: Dora Charlotte Reckeweg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Wash San - Hosp Chart

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO (b): Old Ant myocardial Infarction — ?
DUE TO (c): Arteriosclerotic Process

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None?

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/18/ 19.62, to 3/27 19.62 that (I) (we) last saw the deceased alive on 3/26 19.62 and that death occured at 7:12 A.M., from the causes and on the date stated above.

22a. SIGNATURE: A Hobbs, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Chas H Wolohan
22d. ADDRESS: 7401 Blair Road, N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/30/1962
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem. - Arlington, Virginia
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: H. Hines Co.
ADDRESS: 2901 14th St NW
25a. REC'D BY REGISTRAR DATE MAR 29 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruna

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03538 **CERTIFICATE OF DEATH** 03531

1 M

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 12
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Takoma P. Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, 17
d. STREET ADDRESS: 717 Erie Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75

**3. NAME OF DECEASED** (Type or print): First: Junius — Middle: Earl — Last: Sowers

**4. DATE OF DEATH**: Month: March — Day: 14 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 7-14-86

**9. AGE** (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Engineer - Boiler Room

**10b. KIND OF BUSINESS OR INDUSTRY**: Engineer - College

**11. BIRTHPLACE** (County & State, or foreign country):

**12. CITIZEN OF WHAT COUNTRY?**: American

**13. FATHER'S NAME**: John W. Sowers

**14. MOTHER'S MAIDEN NAME**: Demerris Dickerson

I

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): Unknown — (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Chart — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subphrenic abscess
540.0
DUE TO (b): Leak thru stomach wall
DUE TO (c): Partial resection of stomach for ulcer

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive heart disease

2

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Feb 20, 1962 to Mar 14, 1962, that (I) (we) last saw the deceased alive on March 14 1962, and that death occured 6:50 p.M. from the causes and on the date stated above.

**22a. SIGNATURE**: W W Eastman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**:

**22c. PHYSICIAN'S NAME** (Type): W. W. EASTMAN

**22d. ADDRESS**: 8700 Colesville Rd, Silver Spring Md

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**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: March 16, 1962

**23c. NAME OF CEMETERY OR CREMATORY**: George Washington Cemetery

**23d. LOCATION** (City, town or county) (State): Adelphi. Maryland.

**24 FUNERAL DIRECTOR'S SIGNATURE**: J. Arthur Walters — **ADDRESS**: 254 Carroll St. N.W. Wash. D.C.

**25a. REC'D BY REGISTRAR** DATE: MAR 19 62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03539 **CERTIFICATE OF DEATH** 03532

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**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Silver Spring
d. STREET ADDRESS: 2300 Colston Drive—Apt.102
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Madge — Middle: S. (Shaw) — Last: Sponseller

**4. DATE OF DEATH**: Month: March — Day: 3, — Year: 19 62

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: 9/18/78
**9. AGE** (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home
**11. BIRTHPLACE** (County & State, or foreign country): Maryland
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Frank T. Shaw
**14. MOTHER'S MAIDEN NAME**: Myra Cull

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No. — (If yes give wars or dates of service): None
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT**: Donald Sponseller 36 Count St. ~~Westminster,~~ Address Westminster, Md.

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO (b) Arteriosclerotic Heart Disease — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1957, to 3/3 1962, that (I) (we) last saw the deceased alive on March 2 1962 and that death occured at 5:30 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: J. Marion Bankhead M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3/3/62
**22c. PHYSICIAN'S NAME** (Type): J. Marion Bankhead
**22d. ADDRESS**: 9241 Col. Blvd. Silver Spring Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-5-62
**23c. NAME OF CEMETERY OR CREMATORY**: Westminster Cemetery
**23d. LOCATION** (City, town or county) (State): Westminster Carroll Co, Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Zeiler — ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Maryland
**25a. REC'D BY REGISTRAR** DATE: MAR 7 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Thomas

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03540 **CERTIFICATE OF DEATH** 03533

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 4212B Knox Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Alford Palmer Stark
4. DATE OF DEATH: Month: March; Day: 26; Year: 1962
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 2, 1884
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Naval Officer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jeremiah M. Stark
14. MOTHER'S MAIDEN NAME: Serena V. Mattox
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW I & WW II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife: Mrs. Mae E. Stark, Same as #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas with widespread metatisis
DUE TO (b) Terminal intestinal hemorrhage
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from March 19, 1962, to March 26, 1962, that ☒ (we) last saw the deceased alive on March 26, 1962, and that death occured at 6:25 AM from the causes and on the date stated above.

22a. SIGNATURE: D. L. Kettering LT MC M.D.
22b. DATE SIGNED: March 26, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): D. L. KETTERING LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-28-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: J. Stone
ADDRESS: GASCH FUNERAL HOME, HYATTSVILLE, MARYLAND
25a. REC'D BY REGISTRAR DATE MAR 28 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

VR A15 (4)
1SM 7/61

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Item 18 Film 309 3-23

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03541 **CERTIFICATE OF DEATH** 03534

1 M

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 23 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Louisiana
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bossier City 56X·3
d. STREET ADDRESS: 433 Riverdale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Shirley Middle: Ann Last: Stevens

**4. DATE OF DEATH**: Month: March Day: 16, Year: 19 62

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: 14 January 1957
**9. AGE** (In years last birthday): 5 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Child
**10b. KIND OF BUSINESS OR INDUSTRY**: None
**11. BIRTHPLACE** (County & State, or foreign country): Louisiana
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Joel B. Stevens
**14. MOTHER'S MAIDEN NAME**: Roberta Summers

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service)
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT**: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b) Probable Septicemia — 3 Weeks
DUE TO (c) Acute Lymphocytic Leukemia with Hepato splenomegaly — 1 Year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

204.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Feb. 21, 1962, to March 16, 1962 that (I) (we) last saw the deceased alive on March 16, 1962, and that death occured at 3:07 PM from the causes and on the date stated above.

**22a. SIGNATURE**: J. David Heywood M.D.
**22b. DATE SIGNED**: 3-16-62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22c. PHYSICIAN'S NAME** (Type): J. David Heywood M.D. M.D.
**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**23b. DATE THEREOF**: 3/20/62
**23c. NAME OF CEMETERY OR CREMATORY**: HILL CREST CEMETERY
**23d. LOCATION** (City, town or county) (State): BOSSIER PARRISH LOUISIANA

**24 FUNERAL DIRECTOR'S SIGNATURE**: W.W. Chambers
**ADDRESS**: 1400 Chapin ST. N.W. WASH. D.C.
**25a. REC'D BY REGISTRAR** DATE: MAR 20 '62
**25b. REGISTRAR'S SIGNATURE**: Clifton S. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN**: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03542 **CERTIFICATE OF DEATH** 03535

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San. and Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Hyattsville 1658-2
d. STREET ADDRESS: 6702 West Park Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Carrie Middle: (NMN) Last: Stiefel

**4. DATE OF DEATH**: Month: March Day: 13 Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
**8. DATE OF BIRTH**: 10-5-89
**9. AGE** (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House wife
**10b. KIND OF BUSINESS OR INDUSTRY**: At Home
**11. BIRTHPLACE** (County & State, or foreign country): Hungary
**12. CITIZEN OF WHAT COUNTRY?**: American

**13. FATHER'S NAME**: Adolph Fisher
**14. MOTHER'S MAIDEN NAME**: Julia Eckstein

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service):
**16. SOCIAL SECURITY NO.**: 091-14-2349
**17. INFORMANT**: Address: Park West Memorial Chapel - New York

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.1
DUE TO (b) Hypertensive cardio-vascular disease — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

MEDICAL CERTIFICATION

**20a.** ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
**20c.** TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
**20d.** INJURY OCCURRED While at work ☐ Not While at work ☐
**20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) ~~(this hospital)~~ attended the deceased from 2-23, 1962 to 3-13, 1962 thet (I) ~~(we)~~ last saw the deceased alive on 3-13 1962, and that death occured at 10:05 P.M, from the causes and on the date stated above.

**22a.** SIGNATURE: Eino Magi, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b.** DATE SIGNED: 3-13-62
**22c.** PHYSICIAN'S NAME (Type): EINO MAGI
**22d.** ADDRESS: 918 Univ. Blvd. E. Silver Spring, Md.

**23a.** BURIAL, CREMATION, REMOVAL (Specify): Removal
**23b.** DATE THEREOF: 3/14/62
**23c.** NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
**23d.** LOCATION (City, town or county) (State): Rochelle Park, New Jersey

**24** FUNERAL DIRECTOR'S SIGNATURE: Sol Funeral Bros Inc. ADDRESS: 6010 Reisterstown Rd.
**25a.** REC'D BY REGISTRAR DATE MAR 15 '62
**25b.** REGISTRAR'S SIGNATURE: Anthony S. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03543 **CERTIFICATE OF DEATH** 03536

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 51 I 0 1

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Wheaton
d. STREET ADDRESS: 3812 Greenly Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: David — Middle: Hugh — Last: Strohmeyer

**4. DATE OF DEATH**: Month: March — Day: 15, — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Caucasian

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: December 22, 1961

**9. AGE** (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: 2 Days: 21 — IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): ------

**10b. KIND OF BUSINESS OR INDUSTRY**: ------

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**:

**13. FATHER'S NAME**: John H. Strohmeyer

**14. MOTHER'S MAIDEN NAME**: Joyce Aileen Parr

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

(If yes give war or dates of service): ------

**16. SOCIAL SECURITY NO.**: ------

**17. INFORMANT**: Hospital Records — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Tricuspid Atresia (Post operative) — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 mo.
DUE TO (b)
DUE TO (c)
754.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (X) (this hospital) attended the deceased from March 12, 1962 to March 15, 1962, that (X) (we) last saw the deceased alive on March 15, 1962, and that death occured 4:21 PM from the causes and on the date stated above.

**22a. SIGNATURE** J. L. Beeby M.D.

**22b. DATE SIGNED**

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22c. PHYSICIAN'S NAME** (Type): J. L. BEEBY LT MC USN

**22d. ADDRESS**: U. S. Naval Hospital, Bethesda, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-19-62

**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National

**23d. LOCATION** (City, town or county) (State): Arlington, Virginia

**24. FUNERAL DIRECTOR'S SIGNATURE**: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave.

**25a. REC'D BY REGISTRAR** DATE: MAR 19 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Krauss

VR A1S (4)
1SM 7/61

1-031421

1 FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03544 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 03537

**1. PLACE OF DEATH**
a. COUNTY: Bethesda Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Bethesda
d. STREET ADDRESS: 4511 Amherst Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Hazel; Middle: V.; Last: Styers

**4. DATE OF DEATH**: Month: March; Day: 3; Year: 19 62

**5. SEX**: Female

**6. COLOR OR RACE**: white

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Aug. 14, 1912

**9. AGE** (In years last birthday): 49 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): ~~XXXXXX~~ Va. Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Henry Nine

**14. MOTHER'S MAIDEN NAME**: Claudie Baxley

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: Paul - same as above - Husband Address

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral edema
DUE TO (b) Cerebral hemorrhage
DUE TO (c) Ruptured aneurysm - rt mid. cerebral artery

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

330X

INTERVAL BETWEEN ONSET AND DEATH: 19 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
Was pushing auto at home when she became ill + collapsed

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: Mar 3 1962

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**22b. DATE THEREOF**: 3/6/62
**22c. NAME OF CEMETERY OR CREMATORY**: Arlington Nat. Cem.
**22d. LOCATION** (City, town, or country) (State): Arlington, Virginia

**23. FUNERAL DIRECTOR** ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

**24a. REC'D BY REGISTRAR** DATE: MAR 7 '62
**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03545 **CERTIFICATE OF DEATH** 03538

1. **PLACE OF DEATH**
a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 17 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. (D.C.)
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WASHINGTON 16
d. STREET ADDRESS: 5510 Ridgefield Rd.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): WILLIAM S. SUMMERS (First, Middle, Last)

**DATE OF DEATH**: March (Month) 10 (Day) 19 62 (Year)

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/30/84
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILLIAM SUMMERS
14. MOTHER'S MAIDEN NAME: SARAH Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577 03 8558
17. **INFORMANT**: daughter) Mrs. Olive O'Connor Address: Same as above

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Hypertension — 2 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 2, 1962 to March 10, 1962, that (I) (we) last saw the deceased alive on March 10 1962, and that death occured at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Dr Joseph Kenrick M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/10/62
22c. PHYSICIAN'S NAME (Type): Dr Joseph P. Kenrick
22d. ADDRESS: 6450 Wisconsin Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-13-1962
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland, Md

24 FUNERAL DIRECTOR'S SIGNATURE: K. A. Mattingly ADDRESS: 131-11th St. S.E. Wash. DC
25a. REC'D BY REGISTRAR DATE MAR 12 '62
25b. REGISTRAR'S SIGNATURE: Clifford S. Krauss

**TO HOSPITAL ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03546

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03539

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital ~~Wesbrooman-Siz & Cedar Lawn~~

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md
b. COUNTY Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Wheaton
d. STREET ADDRESS 3110 Henderson Ave.
a. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print) First: Joyce Middle: Ellen Last: Tweney
4. DATE OF DEATH Month: 3 Day: 19 Year: 1962
5. SEX Female
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH 5/30/29
9. AGE (In years last birthday) 32 yrs. IF UNDER 1 YEAR: Months, Days IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ~~Reg. Nurse~~ Cafeteria Asst.
10b. KIND OF BUSINESS OR INDUSTRY Radnor Elementary School
11. BIRTHPLACE (State or foreign country) DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Raymond Hough
14. MOTHER'S MAIDEN NAME Louise Legge
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service) None
16. SOCIAL SECURITY NO. 229-26-9888
17. INFORMANT Bernard Sweney Address Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Laceration of Cord — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b) Fracture & dislocation C5
DUE TO
(c) Auto accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Was driver of car in which a truck upset
20c. TIME OF INJURY Hour 2:25 p.m. Month, Day, Year 3-19 1962
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) Bethesda (County) Montg (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Frank J. Broschart M.D.
EXAMINER'S NAME (Type) FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
DATE SIGNED 3-20-62

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-23-62
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery
22d. LOCATION (City, town, or country) Arlington, Virginia (State)

23. FUNERAL DIRECTOR Raymond A. Zicka ADDRESS 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE MAR 22 '62
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03547 03540

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Sanitarium

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Bethesda
d. STREET ADDRESS: 6009 Rossmore Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First MARY — Middle ESTELLE — Last SWOPE

**4. DATE OF DEATH**: Month March — Day 18, — Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 3, 1879
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months 4, Days 15 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Alexandria, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Manley T. Rust
14. MOTHER'S MAIDEN NAME: Mary Estelle Nevett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Daughter — Address: Mrs. Dorothy Zimowski

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 WK
DUE TO
(b) GENERALIZED ARTERIOSCLEROSIS — 10 YRS
DUE TO
(c) ADVANCING YEARS (OLD AGE)

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JAN 15, 1962 to 3/18, 1962 that (I) (we) last saw the deceased alive on 3/16, 1962, and that death occured at 4:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
22b. DATE SIGNED: 3/19/62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): GEO I DONOVAN M.D.
22d. ADDRESS: 8218 Wisconsin Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/21/62
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAR 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03548 **CERTIFICATE OF DEATH** 03541

1 M 74 I 2 1

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Rockville
d. STREET ADDRESS: 11901 Rockville Pike Lot J
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Charles — Middle: T. — Last: Tavenner

**4. DATE OF DEATH**: Month: March — Day: 26, — Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/19/19
9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mover
10b. KIND OF BUSINESS OR INDUSTRY: Moving
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Welby Tavenner
14. MOTHER'S MAIDEN NAME: Mary Ellen MacDonough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 223-22-7786
17. INFORMANT — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY Embolus — 1-2h
DUE TO (b) Thrombosis, peripheral veins
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

466X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from March 19, 1962 to March 26, 1962 that (I) (~~we~~) last saw the deceased alive on March 26, 1962 and that death occured at 1:25 AM, from the causes and on the date stated above.

22a. SIGNATURE: John E. Everett M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/26/62
22c. PHYSICIAN'S NAME (Type): JOHN E EVERETT
22d. ADDRESS: 9400 Conn Av. Kensington Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/29/62
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City, town or county) (State): Falls Church Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler — ADDRESS: 1331 East Montgomery Ave Rockville Maryland

25a. REC'D BY REGISTRAR — DATE MAR 29 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03549 **CERTIFICATE OF DEATH** 03542

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 183 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District Of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1719 Monroe Street, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary Thomas; Middle Louise; Last Thomas
4. DATE OF DEATH: Month March; Day 27; Year 1962
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: September 13, 1896
9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George W. Richards
14. MOTHER'S MAIDEN NAME: Lucinda Page
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-30-3756
17. INFORMANT: The Medical Records, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Progressive electrolyte imbalance — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b) Macroglobulinemia with bone and renal disease — 8 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

299X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Sept. 25, 1961, to March 27, 1962 that I (we) last saw the deceased alive on March 27, 1962, and that death occured at 8:25PM from the causes and on the date stated above.

22a. SIGNATURE: Michael Z Lazor M.D.
22b. DATE SIGNED: 3/28/62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Michael Z. Lazor, M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3.30.62
23c. NAME OF CEMETERY OR CREMATORY: WOODLAWN CEMETERY
23d. LOCATION (City, town or county) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert T. Mugan
ADDRESS: 1820 9TH ST, N.W. WASHINGTON, D.C.
25a. REC'D BY REGISTRAR DATE APR 2 '62
25b. REGISTRAR'S SIGNATURE: Clinton S. Travis

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Large or abnormal
sizes of globulin in blood

Age

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03550 **CERTIFICATE OF DEATH** 03543

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 30 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X·3
d. STREET ADDRESS: 3133 Conn Ave. N.W.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Virginia Middle: A. Last: Thompson

**4. DATE OF DEATH** Month: March Day: 13, Year: 1962

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH:** 12/29/79

**9. AGE** (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY:** - - -

**11. BIRTHPLACE** (County & State, or foreign country): D.C.

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Maurice Adler

**14. MOTHER'S MAIDEN NAME:** Gertrude Harper

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No (If yes give war or dates of service): NO

**16. SOCIAL SECURITY NO.:** No

**17. INFORMANT:** Raymond Thompson, son-in-law Address: 119 Hesketh St. Ch. Ch., Md

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure - Acute — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
(b): Acute Myocardial Infarction — 1 mo
DUE TO
(c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Feb 10, 1962 to March 13 1962 that (I) ~~(we)~~ last saw the deceased alive on 3/13 1962, and that death occured at 10:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: W. Fleet Luckett M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Wm. F. Luckett

22d. ADDRESS: 5000 Reno Road, N.W. Washington, D.C

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3-15-1962

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons, Inc. ADDRESS: Washington, D.C. 1756 Pa. Ave. N.W.

25a. REC'D BY REGISTRAR DATE MAR 15 '62

25b. REGISTRAR'S SIGNATURE: Arthur E. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03551 **CERTIFICATE OF DEATH** 03544

Item 21 Film G311 4/16/62 mh

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 31 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 14 Ednor
d. STREET ADDRESS: 1 Millgrove Gardens
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Franklin — Last: Tower
4. DATE OF DEATH: Month: March — Day: 31 — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-26-23
9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Repr. National Park Service
10b. KIND OF BUSINESS OR INDUSTRY: National Park Serv
11. BIRTHPLACE (County & State, or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? Amer.
13. FATHER'S NAME: Franklin Tower
14. MOTHER'S MAIDEN NAME: Florence Harder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW-II
16. SOCIAL SECURITY NO.: 218-24-0844
17. INFORMANT: Hospital Records — Address:

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS
DUE TO (b) SHOCK POST OPERATIVE — 72 HRS
DUE TO (c) CORDOTOMY

154X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ADENOCARCINOMA RECTUM WITH GEN. METASTASIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from MAR 1, 1962, to MAR 31, 1962, that (I) (we) last saw the deceased alive on MAR 30 1962, and that death occured at 4 A.M, from the causes and on the date stated above.

22a. SIGNATURE: John P. Haberlin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3-31-62
22c. PHYSICIAN'S NAME (Type): John P. Haberlin
22d. ADDRESS: 1015 Spring Street, Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-3-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fisher ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE APR 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Hawes

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03552 **CERTIFICATE OF DEATH** 03545

Item 9 Film G309 3/19/62 iwk

M

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. - 47X-3
d. STREET ADDRESS: 808 Aspen Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75

**3. NAME OF DECEASED** (Type or print): First: Carrie — Middle: Ella — Last: Trivett

**4. DATE OF DEATH**: Month: 3 — Day: 12 — Year: 1962

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 3-26-1874

**9. AGE** (In years last birthday): 88 YRS. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): New York

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Barnabas Vrooman

**14. MOTHER'S MAIDEN NAME**: Eleanor Smith

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no — (If yes give war or dates of service): no

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Mrs Engell (niece) — Address: 808 Aspen St NW

I

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

4 43X

DUE TO (b) Hypertensive cardiovascular disease many yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

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**21. I certify** that (I) (~~this hospital~~) attended the deceased from May, 1958, to 12 March, 1962 that (I) (~~we~~) last saw the deceased alive on 12 March 1962, and that death occured at 10:40 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Ernest E. Harmon M.D.

**22b. DATE SIGNED**: 12 Mar 62

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22c. PHYSICIAN'S NAME** (Type): Ernest E. Harmon M.D.

**22d. ADDRESS**: 9301 Colesville Rd Silver Spring Md.

1

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-14-62

**23c. NAME OF CEMETERY OR CREMATORY**: Cedar Hill

**23d. LOCATION** (City, town or county) (State): Suitland Md.

**24. FUNERAL DIRECTOR'S SIGNATURE**: Rose Funeral Home — ADDRESS: Wash. D.C.

**25a. REC'D BY REGISTRAR** DATE MAR 15 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur J. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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FOR STATE HEALTH DEPT.

M

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any c[illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03553 03546

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Germantown - rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Found Off River Rd. - in woods

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: 15X-1
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Middle: Girl Last: Unknown
4. DATE OF DEATH: Month: Mar Day: 18 Year: 1962
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 7 mo yrs. IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours; Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Unknown - Estimated 7 mo fetus
DUE TO (b) found in gallon jar - Cord tied.
DUE TO (c) Had been dead for several weeks

795.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: Mar 18 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/62
22c. NAME OF CEMETERY OR CREMATORY: County Alms House Cemetery
22d. LOCATION (City, town, or county) (State): Montgomery County, Maryland

23. FUNERAL DIRECTOR: Tyson Wheeler Funeral Home
ADDRESS: 1331 E. Montg. Ave. Rockville, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 22 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Keene

2-057626

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03554 **CERTIFICATE OF DEATH** 03547

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 month.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Oakhaven Convalescent Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 7808 Boston Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Hanna Middle Mathilda Last Van Dine
4. DATE OF DEATH: Month March Day 20 Year 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 15, 1876
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Karl Torngren
14. MOTHER'S MAIDEN NAME: Gertrude Gustaveson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Helmar Van Dine Address: 7808 Boston Ave. Silver Spring Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wk.
DUE TO
(b) Generalized cardiovasc. disease (arteriosclerotic) — 3 yr.
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): Fracture left hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 2, 1962 to March 20, 1962 that (I) (we) last saw the deceased alive on 20 March 1962 and that death occured at 8:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Cuss E Edlavitch M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-24-62
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Bladensburg Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Leal Funeral Home ADDRESS: 4812 Ga Ave N.W.
25a. REC'D BY REGISTRAR DATE MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03555 **CERTIFICATE OF DEATH** 03548

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Gilmore Rest Home

**2. USUAL RESIDENCE** (Where decedent lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09 Rockville
d. STREET ADDRESS: 804 Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First JENNIE Middle L. Last VAN SICKLE

**4. DATE OF DEATH**: Month March Day 26, Year 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 7, 1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Kindred
14. MOTHER'S MAIDEN NAME: Susanna Wenner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: F.A. VanSickle - Item # 2 — Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: six months
DUE TO (b) ARTERIAL HYPERTENSION — 20 years
DUE TO (c) ARTERIOSCLEROSIS — 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Jan 2 1956 to Mar 26, 1962 that (I) ~~(we) last~~ saw the deceased alive on Jan 23 1962, and that death occured at 9:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Gordon S. Rosenberger M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3/26/62
22c. PHYSICIAN'S NAME (Type): Gordon S. Rosenberger, M.D.
22d. ADDRESS: 310 W. Montg. Ave, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/28/62
23c. NAME OF CEMETERY OR CREMATORY: Union
23d. LOCATION (City, town or county) (State): Burtonsville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Montg. Ave. Rockville, Md.
25a. REC'D BY REGISTRAR DATE: MAR 27 '62
25b. REGISTRAR'S SIGNATURE: Lucius S. Krause

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03556 **CERTIFICATE OF DEATH** 03549

1 M 75 I

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. + Hosp.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~Maryland~~ VIRGINIA
b. COUNTY: ~~[illegible]~~ WARREN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~College Park~~ BROWNTOWN
d. STREET ADDRESS: ~~[illegible] College Ave~~ 83 x 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First Minnie; Middle ~~Marie~~ MARIA; Last Van Valey

**4. DATE OF DEATH**: Month 3; Day 8; Year 1962

**5. SEX**: Fe

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 12-12-95

**9. AGE** (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House mother

**10b. KIND OF BUSINESS OR INDUSTRY**: Univ. of Maryland

**11. BIRTHPLACE** (City or Town & State, or foreign country): Collegeville, Pennsylvania ~~Pa~~

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Edwin ~~J.~~ Jesse LaRose

**14. MOTHER'S MAIDEN NAME**: Susan ~~Sarah~~ Hunsicker

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No — (If yes give war or dates of service): None

**16. SOCIAL SECURITY NO.**: 095-30-6200

**17. INFORMANT**: Hospital Records — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 13 days

420.1

DUE TO (b): Coronary atherosclerosis — several years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 1. Bile Peritonitis, Loculated, 2. Diabetes Mellitus, 3. Cholelithiasis, 4. Lower nephron nephrosis

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) ~~(this hospital)~~ attended the deceased from October, 1960 to March 8, 1962 ~~that~~ (I) ~~(we)~~ last saw the deceased alive on March 7, 1962 and that death occured at 1:35 p.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Russell B. Arnold M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: March 9, 1962

**22c. PHYSICIAN'S NAME** (Type): Russell B. Arnold M.D.

**22d. ADDRESS**: 8801 Colesville Road Silver Spring, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-11-62

**23c. NAME OF CEMETERY OR CREMATORY**: Trinity Reformed Church of Collegeville Cemetery

**23d. LOCATION** (City, town or county) (State): Collegeville ~~Cemo~~ Montgomery Co. Pennsylvania

**24 FUNERAL DIRECTOR'S SIGNATURE**: Raymond C. Stokes — ADDRESS: 8434 Georgia Ave

Warner E. Pumphrey, Inc. Silver Spring, Md.

**25a. REC'D BY REGISTRAR** — DATE: MAR 12 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03557 **CERTIFICATE OF DEATH** 03550

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 201 Williamsburg Drive

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Silver Spring
d. STREET ADDRESS: 201 Williamsburg Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: JAMES Middle: FRANCIS Last: VERMILLION

**4. DATE OF DEATH** Month: 3 Day: 18 Year: 1962

**5. SEX**: Male
**6. COLOR OR RACE**: White
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: Aug. 11, 1917
**9. AGE** (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Inspector
**10b. KIND OF BUSINESS OR INDUSTRY**: Pepco
**11. BIRTHPLACE** (State or foreign country): Washington, D.C.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Charles T. Vermillion
**14. MOTHER'S MAIDEN NAME**: Delia Dorsey

**15. WAS DECEASED EVER IN U. S. ARMED FORCES?** (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWII
**16. SOCIAL SECURITY NO.**: 579-03-4441
**17. INFORMANT**: Alice L. Vermillion — Address: 201 Williamsburg Dr, S.S., Md

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: IMMED.
DUE TO (b): ARTERIOSCLEROTIC VASCULAR DIS. — 10 YRS.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PERIPHERAL VASCULAR DISEASE
**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Month, Day, Year — Hour a. m. p. m. — 19
**20d. INJURY OCCURRED** While at work ☐ Not while at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1959 to March 1962, that (I) (—) last saw the deceased alive on 3-15 1962, and that death occurred at 6 A.M., from the causes and on the date stated above.

**22a. SIGNATURE**: Bernard A. Fitzgerald M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3-18-62
**22c. PHYSICIAN'S NAME** (Type): BERNARD A. FITZGERALD
**22d. ADDRESS**: 217 UNIV. BLVD. E. SIL. SP. Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3-21-62
**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National Cemetery
**23d. LOCATION** (City, town, or county) (State): Arlington, Virginia

**24. FUNERAL DIRECTOR'S SIGNATURE**: Raymond A. Ziska
ADDRESS: 8434 Georgia Ave Silver Spring, Maryland
Warner E. Pumphrey, Inc.
**25a. REC'D BY REGISTRAR** DATE: MAR 20 '62
**25b. REGISTRAR'S SIGNATURE**: Charles E. Krause

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER HAS BEEN NOTIFIED AND APPROVES

VR A15 (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03558 03551

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be exec[illegible]in 24 hours after death. Page [illegible] be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely [illegible]ed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 76 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hustontown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Madaline — Last: Vitti

4. DATE OF DEATH: Month: March — Day: 31, — Year: 1962

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 20, 1921
9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jack Hann
14. MOTHER'S MAIDEN NAME: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service): ----------
16. SOCIAL SECURITY NO.: UNK
17. INFORMANT: Samuel J. Vitti — Address: Same As # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Metastatic Carcinoma of Colon — 3 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from January 5, 1962, to March 31, 1962, that ~~I~~ (we) last saw the deceased alive on March 31, 1962, and that death occured at 1:05 AM from the causes and on the date stated above.

22a. SIGNATURE: William P. Baker M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): William P. Baker, LT MC USN
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-3-62
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Pearson Funeral Home, 472 N.Wash. St., Falls Church, Va.
ADDRESS
25a. REC'D BY REGISTRAR — DATE APR 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

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Mulcatte Cemetery Pile 3 Nos.

William Risdon

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03559 **CERTIFICATE OF DEATH** 03552

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Blacksburg, 83x·3
d. STREET ADDRESS: 207 Rose Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: James — Middle: Harris — Last: Wardlaw

**4. DATE OF DEATH**: Month: March — Day: 7, — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 2 December 1913

**9. AGE** (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months: 3 — Days: 5
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Dept. Store Manager

**10b. KIND OF BUSINESS OR INDUSTRY**: Department Store

**11. BIRTHPLACE** (County & State, or foreign country): South Carolina

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Joseph M. Wardlaw

**14. MOTHER'S MAIDEN NAME**: Aurie Cox

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 237-03-3195

**17. INFORMANT**: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aortic Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
411X
DUE TO (b) Aortic Stenosis — 10 years
DUE TO (c) Rheumatic Heart Disease, Inactive — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from March 4, 1962 to March 7, 1962, that (I) (we) last saw the deceased alive on March 7, 1962, and that death occured at 4:30 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: W. B. Berry, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: March 8, 1962

**22c. PHYSICIAN'S NAME** (Type): W. B. Berry, M.D.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Bur-transit

**23b. DATE THEREOF**: 3/8/1962

**23c. NAME OF CEMETERY OR CREMATORY**: Silver Brook

**23d. LOCATION** (City, town or county) (State): Anderson County So. Carolina

**24 FUNERAL DIRECTOR'S SIGNATURE**: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

**25a. REC'D BY REGISTRAR** DATE: MAR 14 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed [illegible] 24 hours after death. Page 1 [illegible] be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03560

## CERTIFICATE OF DEATH

03553

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Damascus
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 26920 Howard Chapel Dr.

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Damascus
d. STREET ADDRESS: 26920 Howard Chapel Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Marshall — Middle: T. — Last: Watkins

**4. DATE OF DEATH**: Month: March — Day: 23 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: April 3, 1886

**9. AGE** (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Laborer

**10b. KIND OF BUSINESS OR INDUSTRY**: Building

**11. BIRTHPLACE** (County & State, or foreign country): Damascus, Md.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Uriah Watkins

**14. MOTHER'S MAIDEN NAME**: Margaret Brown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No

**16. SOCIAL SECURITY NO.** (If yes give wer or dates of service): 578-44-7826

**17. INFORMANT** — Address: Mrs Mattie E. Watkins, Item 2

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
422.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1/15, 1963 to 3/23, 1962, that (I) (we) last saw the deceased alive on 3/23 1962, and that death occured at 7P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: James P. Kerr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3/24/62
**22c. PHYSICIAN'S NAME** (Type): James P. Kerr
**22d. ADDRESS**: Damascus, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**23b. DATE THEREOF**: 3/26/62
**23c. NAME OF CEMETERY OR CREMATORY**: Montgomery Meth.
**23d. LOCATION** (City, town or county) (State): Clagettsville, Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: Olin L. Molesworth
ADDRESS: Damascus, Md.
**25a. REC'D BY REGISTRAR** DATE: MAR 27 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03554

03561

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 9918 Markham St.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 Silver Spring
d. STREET ADDRESS: 9918 Markham St
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First Ruth Middle Gertrude Last Whittemore
4. DATE OF DEATH: Month March Day 4 Year 19 62

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 1, 1913
9. AGE (In years last birthday): 48 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Wash. Hosp. Center
11. BIRTHPLACE (State or foreign country): Washington County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James R. Whitlock
14. MOTHER'S MAIDEN NAME: Susie D. Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Charles H. Whitlock Address: 2014 Drexel St., S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd degree burns involving 100% of body — INTERVAL BETWEEN ONSET AND DEATH: sudden

916.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in bed which was completly burned
20c. TIME OF INJURY: 1:19 a.m. p.m. Month, Day, Year 4/4 1962
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) Silver Spring (County) Montg. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
DATE SIGNED: 4/4/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-6-62
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or country) Arlington, (State) Virginia

23. FUNERAL DIRECTOR: Raymond A. Zieka ADDRESS: 8434 Georgia Ave
Warner E. Pumphrey, Inc. Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE MAR 7 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03562 **CERTIFICATE OF DEATH** 03555

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 9 mo.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 3906 Spruell Court

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 35 Kensington
d. STREET ADDRESS: 3906 Spruell Court
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Roy Middle: R. Last: Wilburn

**4. DATE OF DEATH** Month: March Day: 17 Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 10, 1897
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wm. J. Wilburn
14. MOTHER'S MAIDEN NAME: Annie Durst
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-03-8958
17. INFORMANT: James H. Edwards-Item# 2 Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: June, 1961 (?)
DUE TO (b) Bronchogenic carcinoma — June, 1961
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1 & 2 ✓

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from March 14, 1962 to March 17, 1962, that (I) (~~we~~) last saw the deceased alive on March 14 1962 and that death occured at 9:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: George A. Gray, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): George A. Gray, Jr. M. D.
22d. ADDRESS: 4740 Chevy Chase Dr., Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 3/20/62
23c. NAME OF CEMETERY OR CREMATORY: GRANTSVILLE
23d. LOCATION (City, town or county) (State): GRANTSVILLE, GARRETT C., MD

24 FUNERAL DIRECTOR'S SIGNATURE: Don Newman ADDRESS: Grantsville, Md
25a. REC'D BY REGISTRAR DATE MAR 20 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03563 **CERTIFICATE OF DEATH** 03556

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 — M — 50 — I — 2 — 1

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: North Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Statesville — 70X-3
d. STREET ADDRESS: 402 Hillcrest Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Helen — Middle: Louise — Last: Wilson

**4. DATE OF DEATH**: Month: March — Day: 2 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: December 10, 1922

**9. AGE** (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**: Not applicable

**11. BIRTHPLACE** (County & State, or foreign country): North Carolina

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Bunk Sherrill

**14. MOTHER'S MAIDEN NAME**: Lillian Cline

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give were or dates of service):

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypotension, Circulatory Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
204.3
DUE TO (b) GRAM NEGATIVE SEPTICEMIA — 3 days
DUE TO (c) Acute LYMPHOCYTIC LEUKEMIA — 1 MONTH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (X) (this hospital) attended the deceased from February 28, 1962 to March 2, 1962, that (X) (we) last saw the deceased alive on March 2, 1962, and that death occured at 7:35 PM from the causes and on the date stated above.

**22a. SIGNATURE**: Marvin A. Kirschner M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
**22b. DATE SIGNED**: 3-3-62

**22c. PHYSICIAN'S NAME** (Type): Marvin A. Kirshner, M.D.

**22d. ADDRESS**: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial-transit

**23b. DATE THEREOF**: 3-3-62

**23c. NAME OF CEMETERY OR CREMATORY**: Iredell Memorial Park,

**23d. LOCATION** (City, town or county) (State): Statesville, No. Carolina

**24 FUNERAL DIRECTOR'S SIGNATURE**: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Md.

**25a. REC'D BY REGISTRAR** DATE MAR 7 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kruse

M

1
FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03564

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03557

**1. PLACE OF DEATH**
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville (rural)
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Willard Rd

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Va
b. COUNTY: Tazewell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tomding Mill 83 X 3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Early Middle Homer Last Wingo
4. DATE OF DEATH: Month Mar Day 10 Year 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov-3-1896
9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Wingo
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 223-40-1496
17. INFORMANT: Pierce Wingo — Address: Poolesville Md-R-2

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Internal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Crushed chest
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of left thigh
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in accident
20c. TIME OF INJURY: Hour 7:15 p.m. Month, Day, Year 3-10 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) Poolesville (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 3-10-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/14/62
22c. NAME OF CEMETERY OR CREMATORY: Gillispie
22d. LOCATION (City, town, or country) (State): Tazewell, Virginia
23. FUNERAL DIRECTOR: William B. Hilton, Barnesville, Md
ADDRESS:
24a. REC'D BY REGISTRAR: DATE MAR 15 '62
24b. REGISTRAR'S SIGNATURE: Otway S. Evans

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03565

## CERTIFICATE OF DEATH

03558

**1. PLACE OF DEATH**
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 615 Alabama Ave S.E. Apt#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X3

51

**3. NAME OF DECEASED** (Type or print): First: Paul — Middle: John — Last: WISNIEWSKI

**4. DATE OF DEATH**: Month: March — Day: 26 — Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: Cauc

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 23 March 1962

**9. AGE** (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days: 3
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): - - - -

**10b. KIND OF BUSINESS OR INDUSTRY**: - - - -

**11. BIRTHPLACE** (County & State, or foreign country): Montgomery, Maryland

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Ronald R. Wisniewski

**14. MOTHER'S MAIDEN NAME**: Nancy Ann Sugyik

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT** Address

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO
(b) Post op status 2 days closure of Omphalocele
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that ☒ (this hospital) attended the deceased from 23 March, 19 62 to 26 March, 19 62, that ☒ (we) last saw the deceased alive on 26 March 1962, and that death occured at 1:10 AM from the causes and on the date stated above.

**22a. SIGNATURE** Lawrence G. Thorne M.D.

**22b. DATE SIGNED** 26 March 1962

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22c. PHYSICIAN'S NAME** (Type): L.G. Thorne, LT MC USN

**22d. ADDRESS**: U.S. Naval Hospital Bethesda Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-27-62

**23c. NAME OF CEMETERY OR CREMATORY**: Arlington National

**23d. LOCATION** (City, town or county) (State): Arlington, Virginia

**24 FUNERAL DIRECTOR'S SIGNATURE** Tyson Wheeler
ADDRESS Rockville, Md.
Tyson-Wheeler Funeral Home, 1331 E. Montgomery Ave.

**25a. REC'D BY REGISTRAR** DATE MAR 28 '62

**25b. REGISTRAR'S SIGNATURE** Arthur S. Kraus

2.001982

**TO INSTITUTIONAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03566

## CERTIFICATE OF DEATH

Items 8&9 FilmG311 4/12/62 iwk 03559

**1. PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 15 MINS.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
e. STATE: PENNSYLVANNIA
b. COUNTY: DELAWARD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARDMORE 75X·3
d. STREET ADDRESS: 18 HANNUM DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First HENRIETTA — Middle MARIE — Last WOLF

**4. DATE OF DEATH**: Month 3 — Day 20 — Year 19 62

**5. SEX**: FEMALE

**6. COLOR OR RACE**: WHITE

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: 10-27-~~1892~~ 1892

**9. AGE** (In years last birthday): 69/71 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): RETIRED R. N.

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): ENGLAND

**12. CITIZEN OF WHAT COUNTRY?**: U. S. A.

**13. FATHER'S NAME**: UNKNOWN (PAYTON)

**14. MOTHER'S MAIDEN NAME**: (UNKNOWN)

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO
(If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: NONE

**17. INFORMANT**: HOSPITAL RECORDS — Address:

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MESENTERIC THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS
DUE TO (b) MURAL THROMBOSIS, LEFT AURICLE — 1 MONTH
DUE TO (c) MITRAL STENOSIS — ? 20 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 10X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CEREBRAL THROMBOSIS, LEFT HEMISPHERE

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from FEB. 11, 1962 to MAR. 20, 1962, that (I) (~~we~~) last saw the deceased alive on MAR. 20 1962, and that death occured at 7:30A M, from the causes and on the date stated above.

**22a. SIGNATURE**: Charles S. Whitaker, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 3-20-62

**22c. PHYSICIAN'S NAME** (Type): CHARLES S. WHITAKER, M.D.

**22d. ADDRESS**: CLARKSVILLE, MARYLAND

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 3-24-62

**23c. NAME OF CEMETERY OR CREMATORY**: Westminister

**23d. LOCATION** (City, town or county) (State): Philadelphia, Pa

**24 FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: F.C.Higinbothom, Ellicott City, Md

**25a. REC'D BY REGISTRAR** — DATE: MAR 22 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Thomas

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 1 should be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/6f

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FOR STATE HEALTH DEPT.

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any [illegible] necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03567

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13 & 14 Film G308 3/12/62 jwk

03560

**1. PLACE OF DEATH**
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8600 Manchester Rd

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Silver Spring
d. STREET ADDRESS: 8600 Manchester Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Helen Middle: Hawthorne Last: Zimmerman

**4. DATE OF DEATH**: Month: Mar Day: 5 Year: 1962

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
**8. DATE OF BIRTH**: Sept. 15, 1899
**9. AGE** (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: Own home
**11. BIRTHPLACE** (State or foreign country): N. J.
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: (unknown) ~~Helen~~ John Munn Baldwin
**14. MOTHER'S MAIDEN NAME**: (unknown) // Helen Hawthorne

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): No
(If yes give war or dates of service): None
**16. SOCIAL SECURITY NO.**: 148-07-2731
**17. INFORMANT**: Marcel Zimmerman Address: Flat 2

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO (b) Arterio sclerosis — yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS** PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)
**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19
**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐
**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)
**20f.** (City or town) (County) (State)

**21. I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

**ACTUAL SIGNATURE** Frank J. Broschart M.D.
**EXAMINER'S NAME** (Type) FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
**DATE SIGNED** 3-5-62

**22a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**22b. DATE THEREOF**: 3-7-62
**22c. NAME OF CEMETERY OR CREMATORY**: Arlington National Cemetery
**22d. LOCATION** (City, town, or country) (State): Arlington, Virginia

**23. FUNERAL DIRECTOR**: Raymond A. Zisk ADDRESS 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Maryland
**24a. REC'D BY REGISTRAR** DATE MAR 7 '62
**24b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

3568 03568 Item 2 Film G311 4/24/62 ink 03561

**1. PLACE OF DEATH** a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kensington Gardens Sanitorium

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) a. STATE: Minnesota b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON D.C. 60X-3

d. STREET ADDRESS: 4357 ALTON PL NW 919 - 4th. Avenue N.E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

**3. NAME OF DECEASED** (Type or print): First: FRANCES Middle: K Last: ZIMPRICH

**4. DATE OF DEATH** Month: Mar. Day: 11 Year: 1962

**5. SEX:** F

**6. COLOR OR RACE:** W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH:** 5/15/88

**9. AGE** (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (County & State, or foreign country): Wisconsin

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** J. M. Straus

**14. MOTHER'S MAIDEN NAME:** Margaret Barth

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): NO (If yes give were or dates of service): —

**16. SOCIAL SECURITY NO.:** 577-56-1991

**17. INFORMANT:** MELBA Z. TEMPLEMAN Address: 4357 ALTON PL NW

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis — 1 yrs

DUE TO (b): Generalized arteriosclerosis

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 3/2/62, 19, to 3/11, 1962 that (I) (we) last saw the deceased alive on 3/10 1962 and that death occured at 6:10 A.M. from the causes and on the date stated above.

**22a. SIGNATURE:** Donald Nelson M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): DONALD NELSON MD

**22d. ADDRESS:** 10620 - GA. AVE. SIL. SP. MD.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF:** MARCH 16, 1962

**23c. NAME OF CEMETERY OR CREMATORY:** CATHOLIC CEMETERY

**23d. LOCATION** (City, town or county) (State): AUSTIN, MINNESOTA

**24 FUNERAL DIRECTOR'S SIGNATURE** Address: Timothy Hanlon 4748 - Wisc. Gn.

**25a. REC'D BY REGISTRAR** DATE MAR 19 '62

**25b. REGISTRAR'S SIGNATURE:** Clarence S. Freeman

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 15M 7/61